The Canadian Nurse

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The views expressed in the various articles are the views of the authors and do not necessarily represent the policy or views of The Canadian Nurse *nor of the Canadian Nurses' Association.*

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Between Ourselves

Over the years we have had some very fine and helpful articles from **Dr. S. R. Laycock.** His contribution this month deals with the ***preparation of nurses*** to assume positions of increased responsibility in the hospital and public health fields. More specifically, it outlines the newly developed pattern of post-graduate nursing education that is presently evolving at the University of Saskatchewan. Heretofore, the school of nursing there has prepared students to receive their degree in nursing following the completion of a period of academic study and their undergraduate training in a school of nursing. Dr. Laycock is very familiar with the present-day problems in nursing and well understands the importance of adequate post-graduate education. Turn to the Institutional Nursing Page and read this worthwhile article.

* * *

Though space did not permit him to outline the full nursing details for all the various ***diseases of the eye*** he has described, **Dr. R. G. C. Kelly** has given enough information in his article to permit intelligent nursing care to be given. It is a truism that the written word can never replace practical instruction yet any nurse who wishes to brush up on some of the essential techniques will find valuable suggestions here.

* * *

The article on ***British Columbia's Indians*** has absolutely nothing to do with nursing care or the hospital situation—not even with public health nursing! So if you are interested only in professional topics in this, your official publication, just skip over those pages. If you are interested in the background of one of the important ethnological groups in our population, you will enjoy reading of the strange differences that existed among the native peoples of our most westerly province.

* * *

How often have you heard a mother say, "I will have to ask the children's father about that." Perhaps it was during a visit on behalf of your immunization clinic, perhaps it was when you were discussing the correction of defects found during the course of school health examinations—whenever it was, mother must get father's consent.

This is a normal, reasonable aspect of parental cooperation. It does tend to create a sense of frustration in the nurse whose working hours coincide with "father's" and who either has to rely on mother's interpretation of a need or make an evening visit to see "father" herself. **Mildred I. Walker** goes to the root of the problem in her discussion of the opportunities afforded the ***industrial nurses*** of "reaching the breadwinner with the health message." Close cooperation between nurses in civic health departments and in industry would solve the knotty problems very quickly. If Miss A. at the big industrial plant knew that Miss B. was launching an active immunization campaign at the Child Health Centre, what more logical step could be taken than that Miss A. would use her contacts with the employees to explain the value of preventing a possible siege of illness by the simple technique of having Johnny and Susan immunized. Today, when there are so many homes from which both the parents go out to work, there is greater need than ever before for this close liaison between all health workers in the area.

* * *

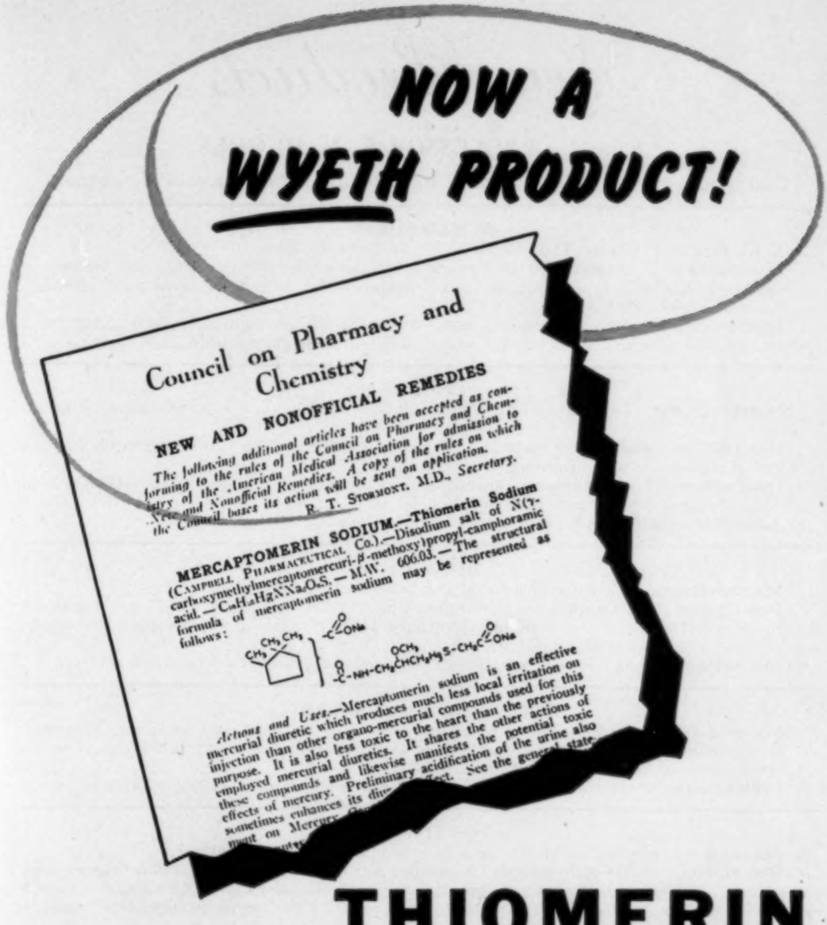
While you are going about your humdrum duties, give a thought to the wonderful opportunity to see new sights that was afforded **Flying Officer M. P. Brown** when she made the patrol with the government officials who were surveying ***health conditions among the Eskimo.*** Perhaps it would be as well to save this article to read on a particularly sweltering day. Then your fancy can carry you far north to those cooler regions where live a truly fascinating race.

* * *

Editorially, we have wished you all ***happy vacations*** this summer. One of our office staff has suggested that if her mother were to read our editorial she would forthwith begin to carry out the cockeyed suggestions made there. After all, it says so in *The Canadian Nurse!* Now don't be foolish but do have a good time and go back to your jobs fully refreshed.

* * *

Our cover lad this month, gay in his favorite clothes, is **Master Peter Kelly** of Montreal.


NOW A WYETH PRODUCT!

Council on Pharmacy and Chemistry

NEW AND NONOFFICIAL REMEDIES

The following additional articles have been accepted as conforming to the rules of the Council on Pharmacy and Chemistry of the American Medical Association for admission to New and Nonofficial Remedies. A copy of the rules on which the Council bases its action will be sent on application.

R. T. Stormont, M.D., *Secretary.*

MERCAPTOMERIN SODIUM.—Thiomerin Sodium (Campbell Pharmaceutical Co.).—Disodium salt of N(γ-carboxymethylmercaptomercuri-β-methoxy)propyl-camphoramic acid.—$C_{16}H_{24}HgNNa_2O_6S$.—M.W. 606.03.—The structural formula of mercaptomerin sodium may be represented as follows:

Actions and Uses.—Mercaptomerin sodium is an effective mercurial diuretic which produces much less local irritation on injection than other organo-mercurial compounds used for this purpose. It is also less toxic to the heart than the previously employed mercurial diuretics. It shares the other actions of these compounds and likewise manifests the potential toxic effects of mercury. Preliminary acidification of the urine also sometimes enhances its diu ffect. See the gene state-ment on Mercury

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New Products

Edited by **PROFESSOR F. N. HUGHES**

PUBLISHED THROUGH COURTESY OF *Canadian Pharmaceutical Journal*

BENA-FEDRIN

Manufacturer—Parke, Davis & Co. Ltd., Walkerville, Ont.

Description—A combination of Benadryl hydrochloride, 0.1 per cent, and Ephedrine (as the hydrochloride), 1 per cent, in isotonic solution for intranasal medication. Readily miscible with nasal secretions.

Indications—Combats congestion associated with allergic rhinitis, including hay fever and other pollen allergies, acute rhinitis, atopic rhinitis, acute rhinosinusitis and sinusitis.

CHOLEX

Manufacturer—Calston Ltd., Toronto, Ont.; sole Canadian representative, John A. Huston Co. Ltd.

Description—Red gelatin capsule, containing 0.5 gm. choline bitartrate, equivalent to 0.24 gm. choline base; well tolerated.

Indications—Treatment and prevention of coronary thrombosis, atherosclerosis and other conditions associated with high blood cholesterol.

Administration—Orally, as directed by physician.

DIRECTALS

Manufacturer—Norwich Pharmacal Company Ltd., Toronto, Ont.

Description—Each suppository contains: Phenylmercuric acetate 0.0077 gr., Dianestol (brand of piperidinopropanediol diphenylurethane HCl), tannic acid, menthol in a water-soluble base. Odorless, non-staining.

Indications—An antiseptic, anesthetic, astringent suppository for hemorrhoids.

FOLVRON-B CAPSULES

Manufacturer—Lederle Laboratories Division, North American Cyanamid, Montreal.

Description—Each capsule contains: 1.7 mg. Folvite (folic acid), 0.194 mg., Ferrous sulphate exsiccated and 5.0 mcg. Vitamin B_{12b}-B_{12}.

Indications—Prevention and treatment of iron-deficient megaloblastic anemias.

FORTIMYCIN

Manufacturer—Ayerst, McKenna & Harrison Limited, Montreal.

Description—Each vial contains, in powder form, 100,000 I.U. Penicillin G potassium (crystalline), 300,000 I.U. Penicillin G procaine (crystalline), and 1 gm. Dihydrostreptomycin sulfate (crystalline) as base. When reconstituted with 2.2 cc. sterile pyrogen-free water, a single 3-cc. dose is obtained.

Indications—Infections caused by bacteria sensitive to either penicillin or streptomycin. Particularly useful pre- and post-operatively in abdominal surgery and in the treatment of infections of uncertain etiology.

TAPAZOLE

Manufacturer—Eli Lilly and Company (Canada) Limited, Toronto, Ont.

Description—5 mg. (scored) tablets of Methimazole, potent antithyroid compound.

Indications—Hyperthyroidism, including prethyroidectomy preparation.

Administration—Initial dose: 15 to 30 mg. daily, divided into 3 doses at 8-hr. intervals. Maintenance dose: 5 to 15 mg. daily, divided into 2 or 3 doses.

TOPAMINIC

Manufacturer—Sharp & Dohme (Canada) Ltd., Toronto, Ont.

Description—Antihistaminic, analgesic cream. Each 100 gm. contains:

Methapyrilene HCl...	2.0 gm.	Benzocaine....................	3.0 gm.
Calamine prepared....	8.0 gm.	Hexylated metacresol..........	0.05 gm.

in a water-washable base.

Indications—Dermatitis venenata and dermatitis medicamentosa (ivy and oak poisoning), atopic dermatitis, eczema, urticaria, summer prurigo, angioneurotic edema, itching dermatoses, dermographia, diaper rash; pruritus ani, vulvae, scroti; insect bites.

Administration—Apply 3 or 4 times daily or as prescribed.

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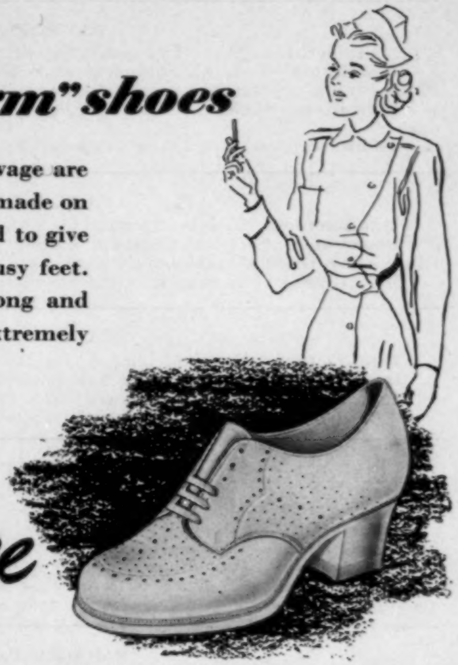

COLOTIO

Manufacturer—Canada Pharmacal Co. Ltd., London, Ont.

Description—Antihistaminic lotion containing camphor, Amosept Solution in a base of aluminum hydroxide gel.

Indications—To relieve itching of measles, poison ivy, etc.

Administration—For external application.

FUNGI-FOOT

Manufacturer—Canada Pharmacal Co. Ltd., London, Ont.

Description—A 2% colloidal dispersion of a quaternary ammonium pentachlorophenate.

Indications—Athlete's foot, ringworm and other fungous infections of the skin.

Administration—For external application.

HEPARIN REPOSITORY

Manufacturer—Lederle Laboratories Division, North American Cyanamid, Montreal.

Description—Heparin in a menstruum of gelatin 16% and dextrose 7.5% for prompt and prolonged anticoagulant effect following subcutaneous administration. Each cc. contains 200 mg. (20,000 units) heparin.

Indications—Prevention and treatment of thrombosis and embolism.

Administration—Deep subcutaneously.

KAL-O-PHEN LOTION

Manufacturer—Barlow-Maney Laboratories Ltd., Hamilton, Ont.

Description—Contains:

Calamine prepared NF VI..	320 gm.	Phenol....................	40 cc.
Zinc oxide U.S.P. XI......	320 gm.	Soluble rose................	30 cc.
		(Special non-separating base)	

Indications—Relieving discomfort due to ivy dermatitis, skin eruptions and irritations due to food, drug, and chemical allergies. Also as an aid in relieving itching from sunburn and insect bites.

NEUROPHEN

Manufacturer—Moore-Thompson-Clinger Ltd., Hamilton, Ont.

Description—Each white compressed tablet contains: Acetylsalicylic acid 3½ gr., Phenacetin 2½ gr., Caffeine citrate ¼ gr., Acetanilid 1½ gr., Tr. Gelsemium 5 min.

Indications—Useful in facial neuralgia, dysmenorrhea, migraine and pain of nervous origin.

Administration—1 to 2 tablets as prescribed.

CAL-D-CAL

Manufacturer—Canada Pharmacal Co. Ltd., London, Ont.

Description—Each tablet contains: Calcium phosphate tribasic 5 gr., Vitamin A 3,500 I.U., Vitamin D 350 I.U., calcium gluconate 3 gr.

Indications—Calcium nutritional deficiencies.

DEXAMPHAMINE

Manufacturer—Bell-Craig Limited, Toronto, Ont.

Description—Scored tablets, each tablet containing 5 mg. Dextro-amphetamine Sulfate.

Indications—Depressive or anxiety states, narcolepsy, and the management of obesity.

Administration—One tablet every four hours or as prescribed.

CYCOTIN

Manufacturer—Reed & Carnrick (Canada) Ltd.; distributor, W. Lloyd Wood, Toronto, Ont.

Description—An appetite depressant with bulk. Each tablet contains: Methyl-cellulose 500 mg., d-Amphetamine phosphate 1.67 mg.

Indications—For use in management of obesity.

Administration—3 tablets with full glass of water a half-hour before meals. Reduce dose to individual requirements. Use with caution in hypertension and cardiovascular disease.

PABACEE Tablets

Manufacturer—Barlow-Maney Laboratories Ltd., Hamilton, Ont.

Description—Each tablet contains:

Sodium salicylate	0.2 gm.	Menadione (Vit. K_3)	0.25 mg.
Ascorbic acid	10 mg.	Calcium Para-aminobenzoate	0.1 gm.

Indications—Rheumatic fever, myalgia, and other conditions in which salicylate therapy is indicated.

Administration—3 tablets every 3 hours or more if required. Contraindicated in renal insufficiency. Should not be administered with sulfonamides or within a 24-hour period preceding sulfonamide therapy.

PALUDRINE

Manufacturer—Ayerst, McKenna & Harrison Ltd., Montreal. Made in Canada by arrangement with Imperial Chemical (Pharmaceuticals) Ltd.

Description—Each tablet contains 0.1 gm. Proguanil hydrochloride.

Indications—Prophylaxis, suppression and treatment of malaria.

FORALAMIN FUMARATE

Manufacturer—Eaton Laboratories Inc., Toronto, Ont.

Description—Brand of Methafurylene fumarate (N-2-furyl methyl-N-2-pyridyl-N',N'-dimethyl-ethylenediamine fumarate) an antihistamine with low incidence of side actions.

Indications—Symptomatic treatment of such allergic manifestations as: coryza, pollenosis, allergic rhinitis and conjunctivitis, urticaria, contact dermatoses, atopic eczema, pruritic dermatoses, allergic cephalalgia.

Administration—Average adult dose: 50 mg. 3 or 4 times daily, preferably immediately after meals and on retiring. Children, 6 years and older: 25 mg. 2 to 4 times daily.

AUREOMYCIN PHARYNGETS

Manufacturer—Lederle Laboratories Division, North American Cyanamid, Montreal.

Description—Palatable troches of Aureomycin HCl Crystalline, 15 mg.

Indications—Local treatment of oral and oropharyngeal infections due to susceptible organisms.

Administration—1 or 2 dissolved slowly in mouth every 2 or 3 hours. Severe infections require systemic use of aureomycin to supplement Pharyngets.

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Remedial English Institute

This institute was held in the nurses' residence of St. Paul's Hospital, Saskatoon, October 26-28, 1950, inclusive.

A representative group of nurses registered. The majority were from the schools of nursing in the province. In addition, nurses from the provincial Department of Public Health, Saskatoon City Health Department, and other interested members of the profession attended.

The institute had been arranged because of requests for an attempt to study methods of improvement in English, particularly in our schools of nursing. The institute, sponsored by the S.R.N.A., was organized and directed by Miss Florence Bennee of the Nutana Collegiate Institute Staff, Saskatoon.

A questionnaire, designed to detect the weaknesses of the students and of the program of instruction in schools of nursing, was discussed in detail. The findings of this preliminary questionnaire formed the basis of the study undertaken. Actual tests, which concerned the problems discussed, were performed by the group. The following topics were included:

1. A general capacity test, with instruction in the method used to find the Intelligence Quotient.
2. Reading tests, including methods of marking and scoring.
3. A minimum essentials test for English.
4. The Quintile Rating Chart by means of which the instructor can appraise the student variation. It shows graphically where a student stands in relation to the normal and if achievement is in correct ratio to ability to learn.
5. Oral reports.
6. How to write examinations.
7. Charting.
8. How to make textbook notes.
9. Spelling. This is a common problem and schools of nursing had previously submitted lists of frequently misspelled words. It was shown that correction of this problem included attention to the

(*Please turn to page 485*)

BERGSTRAIN

He's heard the call for VI-DAYLIN

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Riboflavin	1.5 mg.
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➧ Vitamin B_{12}	1 mcg.
Niacinamide	10 mg.

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The

CANADIAN NURSE

A MONTHLY JOURNAL FOR THE NURSES OF CANADA
PUBLISHED BY THE CANADIAN NURSES' ASSOCIATION

VOLUME FORTY-SEVEN *NUMBER SEVEN*

MONTREAL, JULY, 1951

Holiday Hints

Average reading time — 3 min. 12 sec.

EVERY YEAR hundreds of Canadians lose their lives during the vacation period. Despite strenuous efforts towards the prevention of accidents, despite the use of posters, talks, statistics, and parental punishment, the heavy toll continues. An unthinking moment of carelessness, an attitude of "let's take a chance," or apparent disdain for danger—the unhappy result is the same.

Even when the consequences are not as final as death, uncounted months and years of invalidism may result. Despite their intimate acquaintance with all forms of suffering, nurses are very prone to accidents, too. For the benefit of all those, therefore, who like to flirt with danger, during their holidays especially, we offer some practical suggestions of methods whereby they can ensure for themselves long periods of rest, an opportunity to see what it feels like to be the patient, and more discomfort than they could possibly experience by staying quietly on the job. These hints are guaranteed to bring them so close to sudden demise that the scent of lilies-of-the-valley will be heavy in the air. If we cannot practise what we preach, maybe we should preach what we practise—or do you do these things?

1. Spend the first day of your holidays entirely out of doors in the brightest sunshine you can find. No matter how uncomfortable you may become, stay out there and soak it up. If you are thorough about this, you will not have to worry about any other holiday hazards because you will be able to stay in bed for the rest of your vacation.

2. Don't bother to discover what poison ivy looks like. If you are tramping through the bush or going picnicking, especially in shorts, have never a fear. If poison ivy is there it will introduce itself quickly enough, especially if you stretch out to take a rest.

3. Admire the pretty little stream running down the hill. Don't hesitate to take a good, big drink of that lovely cool water. After all, not all contaminated water contains the organisms of typhoid fever. Still, you may be lucky.

4. We know that unpasteurized milk may produce such diseases as undulant fever, septic sore throat, typhoid fever, dysentery, and bovine tuberculosis. Almost any one of these

Especially at night!

can be depended upon to extend your vacation more or less indefinitely. Make sure that you get your holiday milk supply in its natural, unpasteurized state.

5. A fairly sure way to get a longer holiday is to over-exert yourself daily. This is a particularly helpful method if you haven't taken very much exercise all year. Perhaps there may be a little delay before the extended vacation period commences, but persevere—put your heart into it—then spend a long time wondering what you ever did to cause so much trouble.

6. Always be sure to take a swim immediately after dinner, as soon as it is dark. It is one of the sports that is more fun if no one is around. Also recommended for poor swimmers is a dainty little canoe, especially in deep water. Have no hesitation about moving around in the canoe, particularly if the water is at all rough.

7. A special word about automobiles. Of course the manufacturer expects you to go 100 miles an hour. Why else would that figure be on the speedometer? Through the mountains is an awfully good place to try for speed records because there are no sign-boards for the police to hide behind. Weaving from one side of the road to the other is quite a lark, especially when you turn to see the expressions on the faces of people in the cars you pass.

Seriously though, have a good, refreshing holiday. There is so much work for every nurse today, we can ill afford to spare one of you. Being intelligent women, nurses will take the sort of holiday that is really recreating. Have a happy time!

In the Good Old Days

(*The Canadian Nurse, July 1911*)

"The Graduate Nurses' Association of Ontario has a paid-up membership of 241. New members received during the year, 64."

* * *

"The duties of the nurse in industry are to enquire into and report daily the condition of any sick or injured, and any unhygienic surroundings in the homes, thus enabling the company to better understand the condition of their working people . . . Connected with the factory is an emergency hospital where the sick or injured can obtain immediate relief. The nurse has regular hours for visiting outside patients. These people are free to call upon her any hour during the day, and in very urgent cases at night."

* * *

"A few years ago the medical health officer urged that some effort be made to supply bottle-fed infants with clean milk during the summer months but not enough interest could be aroused at that time to start the matter. The appalling number of infant deaths at the City Hospital and throughout the city last summer brought attention to the question again. A number of medical men in the city considered it carefully, with the result that efforts were made to interest the board of health. These were successful, but when the matter was brought before the Finance Committee and a grant sufficient to warrant starting operations was asked, they were told that the appropriations had all been made for the year. Then the Victorian Order of Nurses Committee told the commission to go ahead with the work and guaranteed to supply the needed funds."

* * *

The total paid circulation at this time was between twelve and thirteen hundred.

Nursing Care in Diseases of the Eye

R. G. C. KELLY, M.D.

Average reading time — 8 min. 48 sec.

IN THIS PAPER I will discuss five diseases of special interest to nurses.

CONJUNCTIVITIS

The conjunctiva is a transparent skin covering the white of the eyeball and the inner surface of the lids. Any of the common organisms such as: staphylococcus, streptococcus, pneumococcus, gonococcus, etc., may cause it to become inflamed. This condition is conjunctivitis. The eyeball becomes red and there is a profuse discharge, which is especially noticeable in the morning. The patient complains of his lids being stuck together on awakening. He does not complain of pain. It is important to remember that this secretion is infectious to the patient's other eye, to those around him, and to the nurse who may have to instil drops. If she should unavoidably touch the lids with the dropper when giving the treatment, the dropper should be boiled, else future drops will be contaminated. The nurse must then wash her own hands for fear of getting the infection herself. The treatment consists of bathing the eye to get rid of secretion and antibiotic drops or ointment three or four times a day.

ACUTE IRITIS

If a patient complains of a red eye which is really painful, he must have something more serious than conjunctivitis. It may well be acute iritis. This is an inflammation of the iris, the colored diaphragm of which the pupil is the centre. It is right inside the eye. With the exception of injury the cause is always from within the body, such as infection from bad teeth, diabetes, etc. The eyeball becomes very red and painful and the vision is blurred. The treatment is divided into investigation of the cause (blood test, x-ray of teeth) and local treatment. We often have to admit the patient to hospital where the nurse carries out local treatment. This consists of hot compresses, followed by atropine salve, or drops, several times a day. Compresses are not only soothing to the patient but do the eye a great deal of good. They should be kept warm for 20 minutes. This necessitates constant attention for that period. The atropine dilates the pupil and keeps it that way. This is all-important in this condition.

GLAUCOMA

In this condition there is excessive pressure within the eyeball. Something interferes with the outlet in the circulation of the fluid in the front of the eyeball. It usually occurs in a person over 40 and is one of the greatest causes of blindness. The pressure may be high and precipitate a grave emergency—acute glaucoma; or it may only be raised slightly, not be enough to cause any discomfort whatsoever—chronic glaucoma.

CHRONIC GLAUCOMA

The nurse has very little to do with the treatment of chronic glaucoma. However, she should be a missionary at large to inform people because vision that is lost by glaucoma is impossible to restore. As mentioned before, the pressure in chronic glaucoma is not enough to make the eye sore. The central visual acuity, that is the ability to read the chart, remains good but the field of vision contracts down and down, so that the patient is looking as through a tube. Sometimes he complains of noticing rings around street lights when he goes out at night. He feels he needs his glasses changed, so gets new ones. He often wastes valuable time by doing so several times. The advice I would like to give you is this. If you see anyone

---

Dr. Kelly is associated with St. Michael's Hospital, Toronto, and Department of Ophthalmology, University of Toronto.

over 40 fussing about his glasses in this manner, he should be sent to an eye specialist, because only the oculist can recognize and deal with this serious condition properly. I repeat, what is lost in this condition is lost forever. If we are given a chance, eyesight can be conserved.

ACUTE GLAUCOMA

The eyeball, in this instance, becomes red and painful. Pain is often severe enough to make the patient ill so that he vomits. Treatment consists of trying for 24 hours to get the pressure down with drops and cold compresses. Operation will likely have to be resorted to at the end of that time. The nurse, of course, is directly concerned with the drops and compresses. The drops which make the pupil small are ordered for every 15 or 20 minutes while the patient is awake. Under no circumstances must they be neglected. A bowl of ice cubes on the bedside table is the best way to maintain the compresses. Putting in drops this frequently may sound rather irksome but after all it is only for 24 hours. The patient has to be operated on if the tension is not reduced by then. If the pressure does come down, the frequency of the drops can be eased and the operation done at some suitable time.

CATARACT

Situated immediately behind the pupil, the lens refracts the light as it passes into the eye. A cataract is an opacity of this lens. When the cataract reaches a sufficient degree of maturity it is removed. To do this, quite a large incision is made in the eyeball. Special care must be taken to prevent any infection of this incision during the healing process. The patient must have good nursing care. Several fundamental principles must be observed at all times.

Preoperative care: The patient usually arrives at the hospital the day before the operation. It is very important that he should have a good rest that night. Such patients are in much better shape in the operating room if they do. To accomplish this, nembutal gr. 1½ is usually given. A laxative is ordered, followed by an enema first thing in the morning. More nembutal—gr. 1½ to 3—is given in the morning depending on the size and age of the patient. Long hair should be braided into two braids. The patient should not be sent to the operating room with bobby pins or hairpins in. It is preferable for the patient to have a light breakfast.

Post-operative care: Many of the strict rules laid down for nursing care were evolved in the days when the oculists were not using sutures. Nowadays they nearly all do. The nurse, therefore, does not have quite so many worries if the patient moves or lifts his head. This does not mean that she can become off-hand or careless in looking after these cases. It must be remembered that the patients are blindfolded, are usually elderly, and often a little deaf. Therefore, it is very easy to frighten them and make them jump. When they do this they often close their lids very tightly. This squeeze either opens the incision or causes an intraocular hemorrhage. People are also inclined to squeeze if they strain in any way or if they are hurt. Whenever anything is going to be done for them, therefore, especially when they are blindfolded, they should be told about it beforehand and warned not to squeeze their eyes. People are inclined to strain when they have a bowel movement. We do not want this, so we keep them on fluids for three days. On the third day they can have a laxative and on the fourth an enema. From then on, if all is well, the patient may get out of bed and eat what he likes.

Not long after the operation the eye begins to get sore. The patient should be given the sedative ordered and not allowed to lie there and suffer. Under no circumstances should morphine be given to a cataract patient. The patient must not lie on the operated side throughout his whole stay in the hospital. The less fussing there is about the care of his back and changing the bed linen, the better. The starched black mask is always used in a cataract case and is essential. The patient should have a minimum of visitors for the first four days.

Some patients get nauseated and vomit after the operation. This is due to a nervous spasm of the stomach. They should be helped in every way to vomit without straining or lifting the head. The doctor should be notified if the vomiting persists. Sometimes 1,000 cc. of 5 per cent glucose helps them greatly.

Every so often a patient develops "cataract mania" which is a real emergency and must be recognized by the nurse and dealt with promptly. This is a definite clinical entity in which the patient becomes irrational, confused, and loses his bearings completely. Some of them even get wildly delirious. The treatment is to uncover the other eye, so the doctor should be called early. We depend on the nurse to report when the patient acts in a peculiar fashion. Often prompt treatment will settle the matter quickly, whereas if it is allowed to go too long, such patients do not come out of it, even after the eye is uncovered, for several days. The patient remembers nothing of his condition and will hardly believe it when you tell him. He is usually ashamed and remorseful. A careful record should be kept of this condition.

DETACHED RETINA

Following the operation for this condition, the patients have to lie quietly in bed for three weeks. If the detachment is below, the head of the bed is raised. If the detachment is on the upper part of the retina, the foot of the bed is elevated and the head lowered. Patients have to stay in these positions for three weeks and cannot help themselves at all during that period. This is a very irksome thing to do and the patient often demands all the skill, kindness, and care of the nurse to help him through. Good post-operative care and good behavior on the part of the patient are just as important as a good operation.

CONCLUSIONS

The nurse is vitally concerned with eye diseases. Eye cases are pleasant to care for because such patients are usually not particularly ill. The nurse has an especially great responsibility in looking after a cataract case. The eyesight and, therefore, the future happiness and earning power of the patient is at stake. The secret is to do nothing that is not absolutely necessary. Do what you have to do in such a way that you are not going to hurt the patient or cause him to strain and squeeze his eye.

Remedial English Institute

(*Concluded from page 479*)

types of image used in learning to spell:

(a) Visual image—the way the word looks.
(b) Auditory image—the way the word sounds.
(c) Speech-motor image—the way the word feels when spoken.
(d) Hand-motor image—the way the word feels when written.

10. A discussion on and practice of remedial reading techniques. The frequency of application was noted as important.
11. Techniques of grammar mechanics. Under this subject the group discussed the use of incomplete sentences, subordination of ideas, proper tense sequence, misplaced modifiers, etc.

Methods of studying and correcting the various difficulties included individual participation and group study. In respect to the latter, the use of group observers was demonstrated. This method provides a means by which the group can "watch itself" as it works to see how it reaches certain conclusions.

The intensive, well-planned preparation for this institute was appreciated heartily by all the participants. It was the general opinion that the many practical suggestions given and practised by the nurses attending could be used in the various fields represented.—MARY P. EDWARDS *and* DOROTHY M. HOPKINS

Aureomycin in the Treatment of Infections

EVA BEAN

Average reading time — 4 min. 48 sec.

AUREOMYCIN IS A comparatively new antibiotic and experiments are still being carried out to determine its effectiveness in the treatment of various types of infection. It had been reported that in test cases it was most effective against *Staphylococcus aureus* infections which had proved penicillin- and streptomycin-resistant. In test cases of *Salmonella* infections the reports were variable. Because of these reports it was decided as a last resort to use it in the treatment of an eight-month-old child with diarrhea. Prior to admission this infant had had an upper respiratory infection and, although this had cleared up, there had apparently been a descending infection causing diarrhea. The infant had been treated with maximum doses of penicillin, sulfa, and streptomycin, as well as being given transfusions and a continuous intravenous when special formulae were not tolerated.

Despite the thorough treatment being given, her condition was not responding to any of them. Her prognosis was certainly poor when the doctor decided to try aureomycin. It could not do any harm and it might help. At noon we gave her a large dose—250 mgm.—and repeated it every four hours. In 24 hours she was showing definite signs of improvement and in two weeks was discharged as cured. It seemed nothing short of miraculous, particularly when we compared it with the result of earlier treatments for diarrhea. In a three-month-period, we had had 24 cases of diarrhea, of whom 10 died. Some of these were admitted from outside the hospital as well as some who contracted it in the hospital, despite careful separate technique. Nasal and throat cultures which were taken showed a hemolytic *Staphylococcus aureus* infection. In a three-month-period in 1950 we had 71 cases in our children's ward and there were seven patients in the premature ward. Some were newborn babies; most were admitted from outside. We have not had one death. Nasal cultures of the newborn showed a *Staphylococcus aureus* infection. It is interesting to note that, in talking to the parents of children admitted with diarrhea, excepting the newborn, they give a history of previously having had an upper respiratory infection—sometimes only a slight nasopharyngitis.

The use of aureomycin does not seem to shorten to any noticeable extent the duration of the illness. Nor does there seem to be any specific total amount required, nor length of time to give the drug. Response is variable, but so far we have had no child who has been criticially ill as the result of diarrhea. The amount given depends on the preference of the doctor. Some give 50 mgm. q. 4 h. x 6 to an infant and comparatively larger amounts to an older child. The amount suggested by the manufacturers is 25 mgm. per 2.2 lb. of body weight per day, given in 4 equal doses —for instance, an infant 8-10 lb. would be given 25 mgm. q. 6 h. An average adult would receive 500 mgm. q. 6 h. We have not noticed a difference in response to the different amounts in the treatment of diarrheas.

There are certain infections where a larger amount is advised but they are uncommon and a definite amount has not been fully determined at present. In some cases aureomycin was not given first—only after there seemed to be little effect from the more routine drugs and treatment. Immediate improvement was noticed but the average number of hospital days per patient seems to be about the same, whether it is given early or late. Among all of our recent cases

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Miss Bean is assistant head nurse on the pediatric ward at the Brantford General Hospital, Ont.

there is only one who has not responded as well but some improvement has been noticed since he was given streptomycin also.

In addition to its use in the treatment of diarrhea, we have used aureomycin in the treatment of pneumonia. Within a day of each other we admitted two children with acute pneumonia, which had been treated unsuccessfully at home with penicillin and sulfa drugs. On admission, the first child was given penicillin and aureomycin 100 mgm. q. 4 h. In two days improvement was evident and in two weeks she was discharged. The other child was given penicillin and streptomycin. At first, she showed a slight improvement, then suddenly became much worse. This time large amounts of aureomycin, 250 mgm. q. 4 h., were given. Within 24 hours she was much improved and at the end of a week appeared cured. She remained another week but there was no recurrence of symptoms.

Aureomycin is available in vials for intravenous use, in capsules of 50 mgm. and 250 mgm., in an ointment, in an ophthalmic solution, and in troches. So far we have used only the capsules. The 250-mgm. size is fairly large and difficult for a child to swallow. We have put the powder from the capsule between layers of jam or in jelly, and the children swallow it easily—if they do so fast enough not to taste it. If they taste it, the least they do is spit it up. Some it makes vomit. Whether or not it is given before, after, or during meals seems to make very little difference to the older child when it is given in the capsule. It is well tolerated.

Infants being lavaged and gavaged are given the drug after the lavage and before the gavage. Bottle-fed infants are more of a problem, since they cannot swallow a capsule. When we tried giving it before a feeding, they would spit it out and refuse their formula. It would not dissolve in the feeding. It settled to the bottom and stuck on the sides. When given directly after the feeding the infant spit it out and too often regurgitated its feeding. We are giving it about 15 minutes after the feeding and putting the powder under the tongue, where it will dissolve and cannot be spit out as easily. When put on top of the tongue, the light fluffy powder causes the infant to cough and choke and, when it dissolves, the infant spits it out. Apparently even an infant is sensitive to the taste and dislikes it as much as does the older child.

When we first started using aureomycin the cost was $1.00 per 100 mgm. The first few days that it was used on our ward it cost the patient $15.00 a day which is a large amount but it saved her life. Now the cost is 26 cents for 50 mgm. and the amount given not usually as great. One of the advantages of this drug, other than its effectiveness in oral administration, is its relative non-toxicity. Occasionally nausea, vomiting, diarrhea, and epigastric distress may occur. These may be controlled by giving one-half the dose every 3 hours or by omitting one or two doses. We have noticed, in one case only, that when the drug was not stopped when the loose stools were controlled, there was a recurrence of loose stools with distention and vomiting. By stopping the drug, these symptoms disappeared in a few hours.

It was with much misgiving yet with hopefulness that we first used aureomycin. It is with much thankfulness that we continue to use it.

The attributes of a great lady may still be found in the rule of the four S's—

Sincerity
Simplicity
Sympathy
Serenity. —Emily Post

Man's ability to absorb knowledge decreases 1 per cent per year after age 25. This means that at 65 you can still absorb knowledge half as fast as you could when you were 25, according to Columbia University psychologists.

British Columbia's Indians

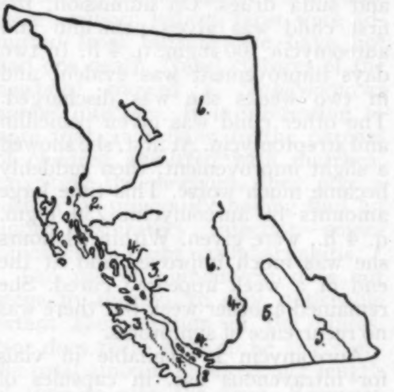
H. W. EGGLESTON

Average reading time — 6 min. 48 sec.

DESPITE MORE than a hundred years of research in an endeavor to discover the origin of British Columbia's Indians, anthropologists at times find themselves very much at variance on several points. The majority of them are firmly of the opinion that the coastal aborigines are a race apart and differ radically from the Indians of the plains. Evidence accumulated over the years supports the theory that they originally came from Asia.

Here and there, the Coastal Indians show some small affinities with the Indians of the plains, but the Rocky Mountains seem to have been as much an ethnological as a geographic boundary. The Indians of the coastal regions are so distinctly Mongoloid as to lend strong color to the claim that the Asiatics were the real discoverers of the Pacific Northwest. Further evidence to support this contention has been revealed from the discovery of Chinese and Japanese junks which were at one time washed up on to British Columbia's shores.

Geographically the Indians of British Columbia are divided into six separate groups: the *Haidas* of the Queen Charlotte Islands$_1$; the *Tsimshians*, along the Skeena and Nass Rivers$_2$; the *Kwakiutl-Nootkas* (pronounced *Kwa-kew-kl*), on the coast and over the greater part of Vancouver Island$_3$; the *Salish* (pronounced *Saylish*) on the eastern flank of the Island range and across the Lower Mainland, with an isolated group in the Bella Coola Valley$_4$; the *Kootenays* in the section to the east of the Selkirk Mountains$_5$; and the *Dénés* distributed widely over the central and northern part of the province$_6$. These tribes in turn are divided and subdivided quite extensively, yet for practical purposes they fall into these main groups.



The Haidas, Tsimshians, and the Kwakiutl-Nootkas had many points in common, as had the interior Salish, Kootenays, and Dénés. Between these two groups there was little similarity, the former being sea-farers and the latter coming nearer to the popular conception of the "red-skin." The use of the past tense in describing British Columbia's Indians does not mean in any sense that they are a vanished race but they have lost many of the attributes which once distinguished them one from another and now seem much alike to the casual observer.

Of them all, the Kwakiutl-Nootkas were the most fiercely intractable. Their war parties raided the Salish villages and harried the early shipping with a bitter intensity. It was one of their parties which attacked and slew the crew of Jacob Astor's ship, the *Tonquin*, in 1811. It is significant that their legendary hero, Kanikilak, had all the characteristics of the Polynesian and the name bears a fairly close resemblance to the

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This illustrated article is published through the courtesy of the British Columbia Government Travel Bureau, Victoria.

Hawaiian term for man which is *kanaka*. They were entirely fearless on land or sea and bodly independent.

The Haidas, in many ways, were the most remarkable of the native races. They were more artistic than the other tribes and their carved totems were splendid specimens. Altogether they seem to have been of a higher order. Their physique was excellent, their features prepossessing, and they excelled upon the sea, riding out the most violent storms in their graceful canoes. Less fiercely aggressive than the Kwakiutl-Nootkas, they were a strong and warlike people and uncommonly industrious.

Capt. Brown carving a Haida totem in slate.

The Tsimshians rivalled the Haidas very closely in numbers, prowess, and artistic ability. In fact, their work in wood, horn, ivory, and stone is quite on a par with similar specimens from the Queen Charlotte Islands. It seems likely that they and the Haidas preceded the Kwakiutl-Nootkas, which might substantiate the belief that the latter came by way of the South Sea Islands. Like the Haidas, the Tsimshians waged war in a manner coldly merciless. All of them made a practice of enslaving their prisoners of war and in many cases the prisoner's lot was apt to be deplorable.

The Salish were distributed quite widely and were (and are) the strongest numerically. They occupied what is now the most thickly-settled part of Vancouver Island—screened from their enemies, the Nootka branch, by the Island mountain range—and the greater portion of the Lower Mainland, with an isolated group in the Bella Coola Valley. They were a peaceful, prosperous people, and stood in the same relation to the coastal tribes as the burghers of the Scottish lowlands to the wild caterans of the hills. They made no art of war but were prepared to fight vigorously when the fight was forced upon them. Their enemies depended a great deal on swift raids and the element of surprise; from a long campaign, probably the Salish would have emerged victorious.

The Dénés occupied an enormous territory, comprising practically the whole of the central and northern interior of the province. They were not a type so much as a loosely-knit group of divergent types with sufficient in common to bring them into one cultural division. The Salish comprised the Cowichan, Bella Coola, Thompson, Lillooet, Okanagan, and Shuswap Indians. The Dénés included the Chilkotin, Takilli (or Carrier), Babine, Sikani, Kaska, and Tahltan Indians. But where the Salish were all modelled on much the same pattern, the Dénés represented a wide range of characteristics.

The Chilkotins were the primitive Tartars. The Carriers were taller and

Their artistic talents are many. Indian sweaters such as this one are knitted by the Cowichan tribe.

Ceremonial costumes were distinctive among the various Indian tribes.

generally of fine physique, with broad, intelligent foreheads. The Sikani were small and slender and much inferior physically. The Babines and Tahltans resembled the Chilkotins, more or less, and the Kaskas had the traits of the Sikani. All of them had bright black eyes, dark, coarse, straight hair, and small hands and feet.

The Kootenays, who were concentrated in the area known now as the East Kootenays, bore the closest resemblance to the plains Indian. It has been suggested that they had nothing in common with the other races of British Columbia but came originally from the prairies—driven through the mountain passes, perhaps, by other tribes who coveted their hunting grounds.

By all accounts, the coastal tribes were organized on the communal plan. The early explorers found them living in community houses, often of enormous size. It was their custom, too, to move *en masse* from place to place according to their seasonal activities. Many of them had both summer and winter quarters. In family matters the family organization of the northern coastal groups was matriarchal and descent was traced from the distaff side. The husband had no real authority and the wife's eldest brother had the deciding voice. Among the Salish, on the other hand, the organization was patriarchal and, in some cases, had developed to the point of being co-parental, where the relatives of both parents formed the kin-group of the children.

The Coast Indians were inclined to be treacherous but it should be remembered that their contacts with the white man were often unfortunate. Frequently they were over-reached and shamefully exploited by the early traders. A vengeful spirit was bred in them which found vent in occasional explosions of ill-will. In the interior, the tribes who did their trading with the Northwest or Hudson's Bay Companies gained a different impression and learned that the white man's word was good, that he did not "speak with a forked tongue." But in the whole course of their subjection, there were no violent uprisings, no wholesale massacres, nor any of the atrocities which splashed the pages of their history in other parts of North America. The proud Haidas, Tsimshians, and Kwakiutls were tamed less by harsh measures than by a show of stern authority, by people who sympathized with the feelings of the dispossessed.

Two-thirds of the responsibility for forest fires is placed on settlers, fishermen, road travellers, and berry pickers, in that order. This estimate is the result of the first Canada-wide survey of forest fire causes and cures made by the Forestry Branch of the Department of Resources and Development at Ottawa. The survey established that in the eastern provinces sport fishermen constitute the greatest problem to forest protective agencies, whereas in western Canada settlers are responsible for the largest number of fires. These originate principally from clearing new land and burning hay meadows.—*C-I-L Oval*

Eastern Arctic Patrol

M. Pauline Brown

Average reading time — 3 min. 36 sec.

THE FAR northeastern territory of Canada has been one of the most inaccessible regions of the world. Over the past three centuries the frontiers of knowledge have been opened to us through those principal characters—explorers, mariners, scientists, and others. It was into these far reaches that the government ship *C.D. Howe* brought subsistence and assistance to the Eskimo populace.

To treat, primarily, of the geographical structure of this great land, one could not be wrong in stating that "the Arctic is tremendous." So far, men have made no more impression on it than would a mouse nibbling on a whale. Baffin Island, one of the largest of the Arctic islands, covering seven ports of call, lies north of the tree area, has a population of 2,000 Eskimoes. I still recall the thrilling wonder of jagged mountains and blue fiords, glittering white icebergs and green waters. In summer the Arctic shrubs and wildflowers bespangle the hills; in winter, I was told, the land is a desolation of rocky emptiness, ridged with snowdrifts.

Eskimoes are a migratory people, scattered in small families or groups of families. He is chiefly a coastal dweller since most of his food and clothing is obtained from the sea, supplemented by the land animals which he hunts inland upon occasion. The eastern Arctic Eskimo has been able to obtain many of the utensils and implements of white civilization but still keeps much of his old mode of living which is a successful adaptation to the limitations of his environment. The seasonal hunting and trapping activities, which are correlated with the habits of the local wild life, make them a difficult people to whom to bring education and medical attention. Our medical party consisted of two medical officers, one dental officer, one nursing sister, an x-ray technician, a dispenser, and a sickbay attendant. The Eskimo population of each little community was brought to the ship, where facilities for medical examinations were complete.

Our experiences in dealing with the Eskimo were varied and were most difficult at times because of our lack of knowledge of their language. That, too, presented its humorous side. For example, the Eskimo word for x-ray is *a-jee-lee-ook-too*. Although I had studied the word and felt a little surge of pride in using it, I became somewhat deflated when the Eskimo stood his ground without a semblance of recognition as to its meaning. Then I discovered the secret of the language is the matter of inflection on the proper syllable—e.g., a-jee-lee-*ook* (as in look)-too.

The following calls were made on Baffin Island. The figures given are the approximate number of men, women, and children who were examined:

Cape Dorset	258
Lake Harbor	206
Pangnirtung (where a government-supported hospital is in operation)	70
River Clyde	20
Pond Inlet	58
Arctic Bay	47
Dundas Harbor, on Devon Island	15
Frobisher Bay (on return journey)	151

When white men first began moving into the Arctic regions the contact with the diseases of civilization, for which the Eskimo had no immunity, decimated their population. A great deal of medical assistance is given the Eskimo by R.C.M.P. officers who have had good first-aid training and who visit the Eskimo on their patrols.

Flying Officer Brown, nursing sister of R.C.A.F. Station, White Horse, Yukon, was sent on this survey by the R.C.A.F. at the request of the Department of National Health and Welfare.

A growing medical problem is illustrated in the fact that the leading known cause of death is found in the 10.5 per cent who have died from tuberculosis. The next largest group, and typical of the dangerous life which the Eskimo leads in his quest for food, is the 9 per cent who die as the result of accidents. The other known causes are similar to those which cause death among any group of people. The most serious problem facing the Eskimo population is the sudden appearance of epidemics which wipe out numbers in local areas. The population, on the whole, has slowly increased in the years since the administration of the Northwest Territory has taken an active hand in overseeing the welfare of the Eskimo. A still greater increase is to be expected with modern medical assistance.

Notable representatives of the white civilization who live among the Eskimo are: members of the Royal Canadian Mounted Police, missionaries, and Department of Transport personnel engaged in the operation of a number of weather observation stations. The majority of these people have become very fond of the Eskimo, finding him trustworthy and intelligent. This comradeship is probably intensified by isolation and mutual dependence. The North may have changed, yet, in all those vast reaches between the few places where men have brought their civilized skills to bear, the North has not actually changed at all.

What Can YOU Do Now?

Helen G. McArthur, M.A.

Average reading time — 6 min. 36 sec

ONE OF THE greatest handicaps Canada has, at the present time, is the fact that it has been fortunate enough to have had very few disasters at home that involve large numbers of individuals. In recent years, the British Columbia and Winnipeg floods, the burning of the *Noronic*, the fires at Cabano and Rimouski have given us some experiences in mass disasters that could have many lessons to teach us if we would study them.

The people of Britain could tell us some of the mistakes they made and some of the ways in which they attained greatness during World War II in handling what we might consider impossible situations. Preparedness for disaster, whether from natural causes or in wartime, can be very much more effective if we listen to the lessons of the past and profit by them.

Training programs in civil defence, as they develop in the provinces, will draw on these experiences. In the meantime, each individual nurse can be studying and thinking of how she would act and react in an emergency. The February issue of *The Canadian Nurse*, with stories on the Winnipeg flood, would be a good place to start.

Authorities tell us that in a time of disaster the medical and nursing professions are not exempt from casualties. Far from it! In Hiroshima 90 per cent of the doctors and nurses were killed or injured. Injuries had to be handled in damaged medical institutions or in improvised ones, and by depleted numbers of doctors and nurses. Leadership must be assumed by the best qualified person on the spot. Because of their greater strength numerically, there is a better chance that a nurse rather than a doctor will be available. The March issue of *The Canadian Nurse* gave the first indications of detailed planning and training for civil defence now under-

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Miss McArthur is national director of nursing services with the Canadian Red Cross Society.

way. They will be completed one of these days. In the meantime must we all just wait?

Picture yourself in any disaster, whether flood, fire or war. You are the only well qualified medical worker on the spot with a great number of casualties around you. Burns, fractures, and all the ills that can beset a community in an emergency are there. What can you do now to get ready for just such a situation should serious, paralyzing disaster strike?

Brush up on your nursing techniques and simplify them to the minimum commensurate with safe practices.

Help inactive nurses in your community to *get refresher courses* in good nursing care, in order that they will be ready to assist you.

Prepare as many *lay people* as possible *in the skills of home nursing and first aid* in order that they will be able to care for themselves and assist you.

Learn to *use volunteers effectively*.

Decide how you would handle a maternity case if no doctor was available.

Take extra training to be able *to do venipunctures* in case there might be blood or plasma available but no doctor to give it.

Review the preparation of formulas for infants. Simplify it enough so that a lay person could follow your instructions.

Think about *how you would dress a burn* if you had no soap or water, no medications.

Practise your first aid. Do you know how to handle a great many fractures, control severe hemorrhage, recognize and treat shock and handle all of these at the same time?

Study the best ways to handle panic on both an individual and mass basis.

Seek ways to simplify records and recognize their importance for identification purposes.

Participate in volunteer organizations set up to act in time of natural disasters such as floods and fires and so gain experience in planning and operations.

Do all these things and do them well. There are lots of jobs to get on with that do not involve specialized knowledge of atomic warfare or any warfare at all for that matter. What is even more important, the doing of them will make you a better nurse, a more useful citizen, a more satisfied individual. Whether or not civil defence planning is ever called into action, your efforts will not be wasted. These things are worth doing no matter what happens. Moreover, get the following "survival secrets" firmly fixed in your minds. The complete pamphlet, "Survival Under Atomic Attack," from which this material is taken, is available from the Canadian Red Cross Society at eight cents per copy. Apply either to your provincial division or to the national headquarters in Toronto.

ALWAYS put first things first and *never* lose your head and—

1. *Try to get shielded.* If you have time, get down in a basement or subway. Should you unexpectedly be caught out of doors, seek shelter alongside a building or jump in any handy ditch or gutter.
2. *Drop flat on ground or floor.* To keep from being tossed about and to lessen the chances of being struck by falling and flying objects, flatten out at the base of a wall or at the bottom of a bank.
3. *Bury your face in your arms.* When you drop flat, hide your eyes in the crook of your elbow. That will protect your face from flash burns, prevent temporary blindness, and keep flying objects out of your eyes.

NEVER lose your head and—

4. *Don't rush outside right after a bombing.* After an air burst, wait a few minutes then go help to fight fires. After other kinds of bursts wait at least one hour to give lingering radiation some chance to die down.
5. *Don't take chances with food or water in open containers.* To prevent radioactive poisoning or disease, select your food and water with care. When there is reason to believe they may be contaminated, stick to canned and bottled things if possible.
6. *Don't start rumors.* In the confusion that follows a bombing, a single rumor might touch off a panic that could cost your life.

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Book Review

Growth and Development of Children, by E. H. Watson, M.D. and G. H. Lowrey, M.D. 260 pages. Published by The Year Book Publishers, 200 E. Illinois St., Chicago. 1951. Illustrated. Price in Canada, $5.75.

Reviewed by S. R. Laycock, M.A., M.Ed., Ph.D., Dean of Education, University of Saskatchewan.

This is a book written by pediatricians for physicians and workers who care for children. While there is a chapter on behavioral development, the essential emphasis is on the physical and psychological development of the child.

Physicians would find the book helpful. So would public health nurses and those who work with children. Parents who have had nurse's training or are accustomed to reading serious works would find the book helpful in guiding and understanding their children's physical development. The book is of limited value to school teachers.

We must take care to indulge only in such generosity as will help our friends and hurt no one—for nothing is generous, if it is not at the same time just.—CICERO

Lyle Creelman *Writes . . .*

Average reading time — 6 min. 48 sec.

THESE COMMENTS come to you from a comfortable seat in a big Swissair DC-4 which is now approaching the southern coast of France. We left Athens this morning in brilliant sunshine but, soon after we were over the Adriatic and all the way across the southern part of Italy, it has been very rough. I need to take my mind off the bumps so will tell you a little about my very interesting two weeks in Athens.

I went to represent the World Health Organization at the conference of the International Council of Women which last met in Philadelphia in 1947. As you know the ICW is, like the International Council of Nurses, composed of national affiliated organizations. It is the oldest international women's organization, being founded in 1888 for the purpose of developing the sense of solidarity and understanding between women in all countries, and to serve as a link between women's organizations throughout the world. I believe that in most of the countries in which there is a National Council of Women and also a National Nursing Association the latter is affiliated with the Council.

In Athens, 20 countries were represented, including Canada. Mrs. Marshall, the Canadian president, presented a very fine report in which she complimented the Canadian Nurses' Association on making arrangements whereby qualified nurses from European countries could take a refresher course to enable them to become qualified in Canada.

Some new countries were taken into affiliation at this meeting—one of them being West Germany from which there were four representatives. It was thrilling to hear them speak of their efforts to unite the women of their country in rebuilding a free and democratic nation.

There were many discussions on the rights of women, especially political rights. At the time of the meeting—and this was probably not a coincidence—a law was passed in the Greek Parliament, giving the women of that country the right to vote in municipal and communal elections. It may surprise you to know that there is still one country in Europe in which women do not have the franchise—Switzerland. It is hoped that before long the women there will share equal political rights with men.

There were many interesting reports and resolutions submitted, in relation to production of educational films, equal educational opportunities for women, equal pay for equal work, etc.

Miss Andromache Tsongas, nutrition adviser of the Food and Agricultural Organization, who was also there as an observer, presented some startling facts in relation to the world's feeding problems. She said:

> It is known that approximately one-half of the people in the world have an average diet of less than 2,150 calories per day. This level of diet is low in calories and, in addition, is oftentimes not of the right kind to provide for health. Statistics show us that in the past 10 years the world population has increased by about 8 per cent or, in other words, there are approximately 55,000 more mouths to feed every day. Food production on the other hand has not kept up with this population increase, so that today there is somewhat less food per person per day than there was 10 years ago. In addition there are indications that the disparities in distribution have widened so that today there are more people whose diets are inadequate for health.

In between the sessions of the Council I found time to see something of the glories of Greece. One day a number of us took a tour to Corinth and Mycenae, passing over the famous Corinth Canal and travelling through a beautiful part of the Peloponnesus. I must confess that I was even more interested in seeing the present-day life of the country people than in viewing famous antiquities. There were many olive groves and vineyards. In the morning the peasant, seated on his donkey, goes off to till his land, probably followed by his flock of one, two or three sheep or goats. His wife accompanies him and, if he owns only one donkey, they take turns in riding. In the evening he returns in the same manner to his village. Rural communities in Greece and many European countries are not like our rural communities; there the people all have their houses in a village with their plots of land in the outside areas. An olive grove, for example, may be owned by several peasants, each having his own group of 50 or so trees. The countryside was covered with flowers — wild roses, poppies, and many other common spring varieties grew in profusion. Higher up there were fields of asphodel and in the grazing areas the gorse was in full bloom.

I remained in Athens a few days after the meetings to visit the schools of nursing and health centres. Greece, a country with a population of 8,000,000, has only four schools of nursing, one of these being a military school. There are approximately 500 students now, with a steady increase in numbers as more facilities are provided. There are many more well-qualified applicants than can be accepted, which indicates a growing interest in nursing as a career for Greek women. All the present schools are in Athens, which creates a serious problem since the nurses do not wish to return to their home towns and villages. The teaching staff is of high calibre and the curriculum excellent. Every student has two months in a public health centre but those who are from the State School of Public Health Nursing have nine months of field work and are eligible for public health nursing positions. The total number of qualified nurses in active work is only 820, of whom 185 are in public health. This indicates the great need for more nurses. In the face of this shortage, the nursing leaders are to be highly commended for their policy of developing slowly and not opening new schools without adequate and qualified teaching personnel. I might add also that, in spite of the shortage, an eight-hour day is achieved.

Just recently the schools had received the sets of anatomical teaching charts and the copies of the Birth Atlas from the War Memorial Committee of the Canadian Nurses' Association. They are already finding the material most helpful and one set has been put aside for the new school which will open in Salonika this fall. This splendid token of assistance from the Canadian nurses is very much appreciated.

Now the sun is shining on the snow-covered Alps—what a contrast to the bare dry hills surrounding Athens! This past winter has been so dry that there is a serious water shortage and, even in these early days of spring, water is available only three times a week.

By the time this appears in the *Journal* I shall be home on leave. I hope I will see many of you and have an opportunity to get caught up on what is going on in Canada.

Your Nurse

It isn't the knowledge she holds in her head,
It isn't the way she corners the bed
That lifts your heart when days are weary,
And smooths the way, makes life more cheery.
It isn't because she's efficient and neat
That you list for the sound of her white-shod feet.
It's the smile on her lip, the light in her eye,
Wee stories from life, as there you lie,
That charm away the pain and fear,
Make all the day more bright appear;
When nights are long, it's the gentle touch
Of interest and kindness that means so much.
It isn't the medal or pin that she wears,
It's the heart of gold. You know she cares!

—MARY M. FORMAN

Institutional Nursing

Educating Leaders for the Nursing Profession

S. R. Laycock, Ph.D.

Average reading time — 6 min. 24 sec.

In the light of today's increasing demands for trained leaders, university schools of nursing must assume their responsibility for providing a type of nursing education which will develop nurses who are competent to give special leadership in the fields of teaching in schools of nursing, public health nursing, and in hospital supervisory and administrative work.

Teaching Personnel in Schools of Nursing

As everyone who has gone to school knows, there are teachers and teachers. This applies equally in schools of nursing. To get high-grade teaching in schools of nursing the instructors should (a) be carefully selected in the first place, (b) have a broad professional knowledge of the fields in which they teach, (c) have training in the skills and techniques of teaching.

First of all, those who will teach others should be carefully selected according to the following criteria:

1. They should be well-adjusted, mentally healthy personalities. It has been demonstrated in the field of general education that the teacher's own personality patterns greatly affect the behavior of her pupils. The "dithery" teacher has a "dithery" classroom and the "bossy" teacher either a meek or resentful one. Any teacher must feel sufficiently secure and adequate that she does not depend for her emotional satisfactions on her class. Aggressions must not be worked off on students. Neither should students be asked to feed a teacher's starved love-life.

2. They should like students, *respect* them, and be glad to be with them. Many well-adjusted people have relatively little interest in people or the "we" feeling—the spirit of the cooperative group which makes for real teaching.

3. They should be of superior intelligence. No teacher who is less than this can be resourceful enough to do vital teaching. They can, of course, lecture, but teaching is *not* mere telling. It is group leadership and group activity. Imparting factual knowledge is often less important than the changing of attitudes.

Good Professional Knowledge Important

Certainly no one can give to others what she hasn't got. Nursing instructors must, therefore, first of all be competent nurses with a good command of both nursing skills and knowledge. There must be no application of Shaw's quip: "Those who can, do; those who can't, teach." Furthermore, as in all teaching, no instructor in nursing can teach to the edge of her subject. She needs to have a much broader knowledge of her topic than the material in the course she teaches. This applies to teachers in public and high school—and in schools of nursing. The nursing instructor must know much more anatomy or chemistry or nursing procedures than she is called upon to use in her teaching.

Developing Skills of Teaching

Again, may it be repeated that

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teaching is not telling. It is even much more than facility in explanation and illustration. It is much nearer to group therapy than to a gramophone record. The newer techniques of teaching, such as group leadership, must be available to the teacher of nurses. She must know a good deal of educational psychology—how people are motivated to learn, how learning takes place, as well as a general understanding of human behavior. She must be in possession of the newer knowledge of group techniques and group dynamics. She should have as adequate a knowledge of teaching procedures as those who teach in public or high schools. This can be best effected if she shares in the practice teaching and in the courses on teaching procedures in schools of education. Some practice teaching under the direction of trained supervisors should be done at the high school level and some in schools of nursing. After all, the teaching needs of student nurses who have just finished high school do not differ materially from their needs in the later years of their high school course.

EDUCATION FOR PUBLIC HEALTH NURSING

For those nurses who will work in the public health field there again arises the problem of selection and education. A public health nurse must, of necessity, like people and understand them. She must be an emotionally secure person with an outgoing personality. Since she will run into an unusually wide variety of situations—and unexpected ones at that—and be considerably on her own, she must be of superior intelligence and highly resourceful. She must have poise, friendliness, and inspire both confidence and confidences.

Since the public health nurse must deal, to a considerable degree, with behavior problems, her education must include courses in mental hygiene, psychiatry, child psychology, and the psychology of adolescence. She should have some introduction to the case study approach to human problems. Since one of her functions is to interpret public health, her education should include a course in speech and group discussion techniques.

PREPARING FOR ADMINISTRATIVE AND SUPERVISORY POSITIONS

Those nurses who are to be given education for supervisory and administrative positions must again be carefully selected. They must feel emotionally secure and adequate. They must be emotionally mature persons who are able to bear the everyday frustrations and difficulties of life without "blowing up." They must have an insight into their own personality make-up and their own problems of adjustment. They must understand the behavior of others. They must be of superior intelligence. They must be able to take responsibility for themselves and others.

Educating nurses for these posts involves giving them a definite course in the principles and practice of supervision. This should be related to the general principles of supervision which are applied in the supervision of teachers in schools and of workers in industry. In addition, there should be a course in the principles and practice of hospital administration. Both of the above courses must provide for on-the-job practice in supervision and administration in hospital situations—under the skilled supervision of those who are responsible for the courses.

Because of the increasing importance of psychosomatic problems, nurses preparing for supervisory and administrative positions should have a course in psychiatry. As Dr. Jonathan Meakins, former professor and dean of medicine at McGill University, said, "*Every* organic illness carries with it an underlay or overlay of mental disturbances."

A SUGGESTED OUTLINE OF EDUCATION

In harmony with the suggestions given in this paper, the University of Saskatchewan School of Nursing has recently revised its five-year program for the "B.Sc. in Nursing" degree. The first two years will be provided in the university and are meant to prepare the students in the basic sciences of chemistry, biology, anatomy, physiology, pathology, and bacteriology, as well as to give an introduction to nursing and some training in elementary psychology, sociology, and mental hygiene. The third and fourth years will be spent in schools of nursing in selected hospitals. The fifth year will be spent at the university and will provide a degree of specialization in the fields of teaching, public health nursing, and supervision and administration. An outline of this fifth year is included.

A.—Teaching	**B.—Supervision and Administration**	**C.—Public Health Nursing**
Required Courses:		
Principles and Practice of Teaching (two half-classes).	Principles and Practice of Supervision.	Principles and Practice of Public Health Nursing, including Vital Statistics, Sanitation, etc. (one and one-half classes).
Anatomy (full class).	Principles and Practice of Hospital Administration.	
Organic Chemistry (half-class).	Psychiatry.	Child Psychology (half-class).
Biochemistry (half-class).		Adolescent Psychology (half-class).
Optional Courses: (two full courses to be selected)		
Psychiatry (full class).	Anatomy.	Psychiatry.
Public Health Nursing (full class).	Bacteriology (full class).	Biology (half-class in Medical Parasitology).
Bacteriology (half-class).	Child Psychology (half-class).	Biology (half-class in Medical Entomology).
Health Education (half-class).	Health Education (half-class).	Health Education (half-class).
Speech (half-class).	Speech (half-class).	Speech (half-class).
Educational Psychology (half-class).	Public Health Nursing.	Anatomy.
Physiology.	Accounting (half-class if available).	
Non-scientific elective, College of Arts & Science (full class).	Non-scientific elective, College of Arts & Science (full class).	Non-scientific elective, College of Arts & Science (full class).
Practice teaching in city schools and schools of nursing (two afternoons a week).	Practice in administration and supervision in local hospitals and appropriate organizations.	Observation and practice in public health nursing in one of the public health units, V.O.N., City Health Dept., etc.

Further graduate work is, of course, highly desirable, but the courses outlined will give a measure of specialization and will, it is hoped, greatly improve the quality of leadership in the nursing profession.

Public Health Nursing

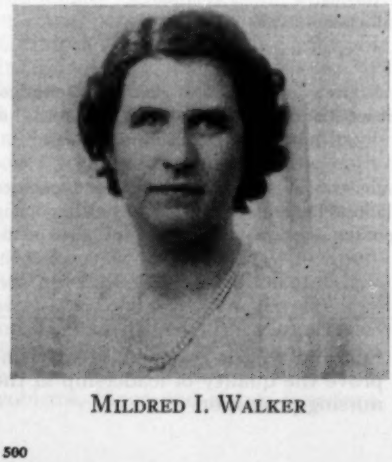
Reaching the Breadwinner with the Health Message

MILDRED I. WALKER, M.A.

Average reading time — 8 min. 24 sec.

THE BAILLIE-CREELMAN Report[1] of the Study Committee on Public Health Practice in Canada (page 68) states:

> Much has been written about the value to both employer and employee of an industrial health service but, to our knowledge, not a great deal of emphasis has been put on the value of such a service to public health generally. In the majority of cases, the employee is the breadwinner. The educational effort of the official health department nurse or the visiting nurse is necessarily directed to mother and children, and the absent member of the household may remain unconvinced. This large group, which could not be so readily contacted through other community health agencies, is reached through the industrial health service in a systematic manner.



MILDRED I. WALKER

To strengthen the observations of the Baillie-Creelman Report we quote from the annual report[2] of a county health department to indicate that reaching the breadwinner with the health message has been recognized as a need in health services for many years:

> When a wage-earner, the breadwinner of a family dies, there are definite and calculable monetary losses involved; the earlier his death, the greater is the financial loss. To the widow and surviving children, it may perhaps make little difference whether the head of the family has died of typhoid fever or of some insidious condition unavoidable in the proper state of medical art. But for the community the matter has a somewhat different aspect, for here the concern is not so much with the individual deaths that have occurred but rather with current and future inroads into the productive capacity of the population as a whole, inroads which, as we know from definite past experience, can be controlled and checked. Our death rate is still padded with many preventable deaths. To let such deaths pass unprevented is, from the humane standpoint, a disquieting thought; from the standpoint of social economics it is, at the least, a matter of inexcusably bad management of our affairs. Clearly, all the means at our command should be brought to bear in the endeavor to bring the longevity of our population nearer to the possible upper limit. Public health work is the organized mechanism to achieve this result.

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A solution should be sought to close this gap in the services to the "absent member" of the family unit referred to in the Report. Closer correlation and integration of services between the nurse in the community health department and the nurse in industry will assist. The absent member to the nurse in the community agency is the present member to the nurse in the industrial health centre. A two-way flow between these two nurses would do much to reduce the lack of response in the breadwinner, a very important member of the family unit being served. The father, the mother, and the children must be viewed as a unit, with all personnel in health and welfare articulating their efforts to build up the self-dependence of the family through healthful living.

Industrial nurses show an increasing awareness of the value of the two-way flow of their service with those of the community agencies. In their group activities and in educational programs they are attempting to increase their efficiency through becoming familiar with these community agencies. It is realized by these nurses that they have a contribution to make to the well-being of the family. It is also recognized by management that the happy worker is a more efficient worker and home problems have their effect on the work pattern in the industry.

Dr. Tourangeau, director of industrial health in the Province of Quebec, has reminded a group of industrial nurses that teamwork and cooperation are nothing less than matters of national emergency and it is their duty to become acquainted with all community resources in the city, the town, the village, the country, and the province where their industry is situated.

> No matter how efficient an industry's health program is, if we confine our work exclusively within the walls of the plant, it will be impossible to attain more than a fraction of one's objective.

In the correlation of health services in industry with those in the community, it must be remembered the industrial health personnel serve private enterprise. Management must be educated to the correlation of these health services for the family as a unit. In the majority of cases the nurse and physician do not find much difficulty here, providing they understand how to present the values of such correlation of service to management. This is a topic for discussion which cannot be enlarged upon here but, in passing, I would like to suggest that the industrial nurse give greater consideration to the methods of interpreting her program to management as a part of the total family health service which necessitates correlation with community agencies.

To strengthen the bonds of the health agencies in the total community, the personnel of the health department should plan to give leadership to all health and welfare personnel. If it is a two-way flow it requires concerted planned effort in good public relations. The health department must keep the industrial nurse in the picture if they are convinced the breadwinner must and can be reached through industrial health services. They must seek the assistance of the nurse in the industrial health centre, keeping in mind hers includes a service to cover emergencies according to the company rules which makes her time of meeting less flexible than those in the health department. Once each knows the other and the scope of their respective programs is understood, the nurse in the industry is readily available by telephone. Take a trip out to meet her, see her service, and meet management responsible for industrial relations within the industry.

The objective of health services in industry is to keep the worker in good health and on the job. When the breadwinner is away from work through illness, the nurse visiting from the community health agency should know if his pay stops, for when it does it is a disturbing factor in the family comfort and well-being. It follows that the personnel in the health agency must know the benefit plan in the respective industries in the community and certainly be conversant with Workmen's Compensation in that province.

The Report says an industrial nursing service is an important adjunct to a public health service. It is much more than this. Industrial health is an integral part of the total health services in Canada. In management and labor relations, health services have moved in from being termed fringe benefits to take an important place in the yearly contract which results from bargaining. In the future industrial health services will give greater leadership in the total health services because of the increasing awareness of health in industry through the general health education of the nation and through health service to the employee at his place of work. Health personnel in industry must and have proved to management and the worker that their services actually save money and manpower as well as increasing the efficiency and happiness of the employee.

As the study suggests, let us make an effort to reach the breadwinner with the health message through the industrial health personnel. This can be accomplished through a two-way flow which follows an awareness of the need to develop an understanding of the service of all personnel in the community whose total objective is to assist the family to develop self-dependence through healthful living.

The health service in industry is a resource to the personnel in public health generally by which they may complete their teaching and services to the family unit. The "absent" member of the family referred to in the Report is more readily convinced at his place of work. He may be reached from the community health agency in several ways. The members of the health agency should:

1. Know every industry in the area they serve, the commodities manufactured, conditions of work, work patterns, hazards, industrial relations within the plant and the status of its total employee group in the community, the benefit plans which go into effect when the worker is ill, a knowledge of which will make the home visiting service more realistic to the family.
2. Become acquainted with those in management responsible within the industry for industrial relations, safety, and the health of the employees, their attitudes towards health.
3. Know the Workmen's Compensation Laws of their province.
4. Develop good public relations by interpreting and making available to management the services the agency has to offer to this industry.
5. Keep the nurses within industry in the community health picture through staff conferences and an active referral system, keeping in mind the time of the nurse in industry is less flexible than most because she frequently works alone and her health centre must be covered for the emergency care of accidents.

With the increasing scarcity of qualified medical and nursing personnel in all areas, as well as an increasing awareness of the importance of health to all Canadian citizens regardless of where they live, every means must be used to get a maximum of production with a minimum of effort in health as well as in industry.

REFERENCES

1. The Baillie-Creelman Report of the Study Committee on Public Health Practice in Canada. June, 1950. Canadian Public Health Association, 150 College St., Toronto 5.

2. Sullivan County, Tennessee Health Department, 1949—We Come of Age. Quote in their foreword from Louis Dublin and Alfred Lotka—The Money Value of Man. Ronald Press, New York, 1930.

Children need to be helped to acquire a sense of trust, autonomy, initiative, accomplishment, identity and integrity. Nurses and doctors can assist parents to develop these qualities in children.

—DR. SAMUEL WISHIK

The importance of the prenatal diet of mothers as a factor in the health and survival of infants at birth and during the first year of life points up the need for more attention to nutritional aspects of pregnancy.

—DR. EDWIN F. DAILY

Aux Infirmières Canadiennes-Françaises

Regards sur l'Avenir

JEANNE FAVREAU

LES GARDE-MALADES spécialisées en hygiène industrielle en la province de Québec se formaient en 1950 en un groupe organisé, maintenant reconnu par l'Association des Infirmières de la Province de Québec sous le titre de "Division Bilingue de la Section d'Hygiène Publique de l'A.I.P.Q." Le but ultime de ce mouvement est de permettre à l'infirmière qualifiée de mieux faire reconnaître son rôle dans le domaine public, attendu que trop souvent on considère encore le poste de l'infirmière en hygiène industrielle comme un poste de tout repos, intimement lié au service de premiers soins pour les malades et les accidentés au travail. Notre société doit s'imposer dans son programme la tâche de rendre les infirmières plus aptes à assumer leurs responsabilités, de nature à satisfaire aux exigences de l'employeur, et contribuer ainsi à améliorer le bien-être physique, moral, et social de l'employé.

Quant aux différents aspects de l'hygiène publique en cette province en marge de l'étude faite par le Dr. J. H. Baillie et Mlle Lyle Creelman (voir "Report of the Study Committee on Public Health Practice" publié en juin, 1950, par Canadian Public Health Association) il serait à propos de relever les faits suivants:

La division bilingue des infirmières de l'industrie de la province de Québec comprend environ 250 membres. De ce nombre, 74 garde-malades de langue française sont de service dans 48 industries, tandis que 42 industries requièrent les services de 80 infirmières de langue anglaise. Ce nouveau groupement des infirmières d'industrie travaillera en coopération étroite avec l'Association de Médecine Industrielle de la Province de Québec et avec la Division de l'Hygiène Industrielle du Ministère Provincial de la Santé.

La nomination dans un avenir rapproché d'une infirmière conseil en hygiène industrielle s'impose tant par les services qu'elle sera appelée à rendre au public que pour répondre aux besoins urgents de notre nouvelle société.

Déjà, une documentation fort variée a été publiée sur les différents problèmes qui touchent l'hygiène industrielle ou la santé au travail. Il appert, cependant, que très peu de publicité a été faite aux services que peuvent rendre et que rendent, en fait, les infirmières de notre groupement à la santé publique.

Dans la plupart des cas, l'employé dont s'occupe l'infirmière en hygiène industrielle est le gagne-pain de la famille et il est presque toujours absent quand passe à la maison la garde-malade du Ministère de la Santé ou la garde-malade visiteuse. Ces dernières doivent donc chercher à faire l'éducation de la mère et des enfants, sans pouvoir atteindre le chef de la famille. Et c'est ici qu'intervient la garde-malade en hygiène industrielle pour compléter de façon systématique le travail commencé par les autres.

Le rapport du Comité d'Etude, que nous avons déjà mentionné plus haut, fait observer que les infirmières de l'industrie peuvent rendre d'immenses services, en particulier les suivants:

Mlle Favreau est infirmière en chef à l'Hydro-Québec.

1. Les premiers soins en général.
2. La collaboration à l'examen médical.
3. La participation au programme d'éducation en matière d'hygiène.
4. La collaboration à l'éducation de l'ouvrier au point de vue sécurité et au travail de prévention des accidents.
5. La participation aux oeuvres sociales.
6. La collaboration à l'assainissement de l'usine ou de l'atelier.
7. Les soins à domicile.
8. La rédaction des notes et rapports.

RECOMMANDATIONS

Pour bien préparer l'infirmière à remplir efficacement son rôle dans l'industrie, voici quelques recommandations que nous tirons toujours du rapport du Baillie-Creelman:

1. Dans toute industrie qui emploie une seule infirmière, celle-ci devrait être spécialisée en hygiène publique.
2. Dans toute industrie qui emploie plus qu'une infirmière la garde-malade en chef, au moins, devrait être spécialisée en hygiène publique.
3. L'infirmière employée dans l'industrie, qu'elle soit spécialisée ou non en hygiène publique, devrait avoir un an ou plus de pratique, en plus de son cours régulier de garde-malade dans un hôpital ou une école de garde-malades.
4. Les universités devraient: (a) Compléter par un cours d'hygiène industrielle le cours d'hygiène publique qu'elles donnent aujourd'hui; (b) donner des conférences et des démonstrations pratiques sur l'hygiène industrielle aux étudiantes en hygiène publique qui se destinent au service de l'industrie; (c) organiser, avec l'aide des infirmières conseils, des programmes de formation postscolaire pour les garde-malades déjà engagées dans l'industrie.
5. Les infirmières en hygiène industrielle, en vertu du principe qu'une chaîne n'est jamais plus forte que le plus faible de ses chaînons, devraient s'intéresser activement à la vie et aux problèmes de leurs associations.

Nous croyons sincèrement que la mise en pratique de ces suggestions devrait aider les infirmières en hygiène industrielle à rendre tous les services que l'employeur, l'employé, et le public en général peuvent attendre d'elles. Elles pourront ainsi faire leur large part pour répandre les bienfaits de l'hygiène et, en même temps, améliorer le standard de vie de l'ouvrier et de sa famille.

The Seamy Side of Travel

DOROTHY M. DENT

MY FIRST YEAR in England I shunned travel—not from lack of interest but fear—fear of buying a ticket for London and ending up in Devon. The few trips I had made, nothing being too good for the Canadian Army, I had always travelled on a first-class ticket but in a third-class coach.

After several such experiences I decided to reverse the procedure and save myself money. One morning I set out for London, my third-class ticket grasped tightly in my hand. I stepped on to the train in sprightly fashion, elbowed my way along gently but with a touch of Canadian Army technique, and found myself a seat. I was no sooner seated than I realized I was in a first-class coach. To my utter dismay, in a few moments, a conductor appeared at the door. He looked twice as large and most unnatural. I waited long enough to hear, "May I see your ticket, please?" to one person. I then got up and, clumsily stumbling over six pairs of feet, blindly turned in the direction of a

(*Please turn to page 525*)

Miss Dent was overseas with the R.C.A.M.C. during World War II.

Trends in Nursing

The Worth of the Human Person

I sometimes wonder whether "the worth of the human person"—to quote the words of the Charter of the United Nations—is fully realized by us or whether by constant repetition the words are coming to lose their meaning. To guard against this danger, we might recall the analogy suggested by the latest developments of science in the world of matter. The atomic bomb is the greatest explosive force that we know in the physical world today. Yet, what starts this tremendous explosion is one single neutron—an infinitesimal, invisible particle which, acting as a kind of gun, first sets off two other guns and then each of these two sets off two others and so on, until there is a terrific force of almost earth-shaking dimensions. What is true of the physical world is also true of the moral: there also we may have vast chain-reactions radiating from a single individual. One of the lessons which we may learn from modern science, therefore, is the importance of the infinitesimally small and, by analogy, the tremendous potential worth of the individual human person and the immense value of individual freedom. If a single individual, organization, or country can set in motion the right kind of idea, it may ultimately move the whole world.—
SIR BENEGAL RAU

Through the Looking Glass

Nurses are a very active group in our Canadian society and every issue of the daily press carries something of interest on nurses and nursing. The following is a brief summary of some of the news that has come to our desk in the past month:

From *Derby, England:* The Derbyshire County Council is considering a proposal by the Mayor of Derby to preserve the house, Lea Hurst, in Holloway, as a memorial to Florence Nightingale.

From *Fredericton, N.B.:* A suggestion was advanced in the Legislature for a subsidy program to aid student nurses in meeting the costs of their training course. The New Brunswick public health nurses report that they are studying the Baillie-Creelman Report; at the Educational Policy Committee meeting lively discussion centred around administration of schools of nursing, costs of financing schools of nursing, present and future requirements for entrance to nursing schools, university education in Canada, and desirable changes in education for nursing. The Institutional Group is planning an institute in the late summer for supervisors and head nurses.

From *Prince Edward Island* comes news of a nutrition series entitled "Fashions in Food."

From *British Columbia* comes news of the organization of a new chapter at Revelstoke. Alice Wright, executive secretary, addressed the meeting and outlined services available through the provincial association. Ferne Trout, who recently attended a course in atomic warfare in San Francisco, gave a course of lectures to the new chapter in May.

From *Lethbridge, Alta.:* The fee for an eight-hour day of private nursing has been raised to $8.00.

From *Ontario:* London reports that 16 nurses have completed the second course in psychiatric nursing arranged jointly by the University of Western Ontario and the Department of Veterans Affairs at Westminster Hospital. While most of the graduates were from Ontario, B.C., Sask., Man., and Quebec were represented. Edith McDowell, dean of nursing at the University of Western Ontario, spoke on the evaluation of graduate nursing service at the one-day regional conference of the Ontario Hospital Association. The Town Council of Port Colborne has voted two $100 scholarships to high school pupils wishing to to enter a nursing school. The Fort William Gyro Club has awarded a scholarship to a student entering McKellar General Hospital. Hospitals in the Kirkland Lake District have increased salaries. Nurses on the staff of the Ontario Society for Crippled Children last year travelled nearly 200,000 miles across 43 counties and visited 4,591 crippled children.

From *Manitoba:* The general secretary of the Canadian Nurses' Association, Gertrude Hall, addressed the annual meeting held in the Fort Garry Hotel, Winnipeg. Her topic was "Looking Ahead for the Nursing Profession." The evening program featured a panel discussion on "The Nursing Team" and a teaching film on cancer.

Important for Nursing

At the Fourth World Assembly held May 7, 1951, informal technical discussion took place on various aspects of the education and training of medical and public health personnel. Daisy Bridges, executive secretary, International Council of Nurses, represented organized nursing in these discussions.

The report of the WHO Expert Committee on Nursing was to be discussed at the April-May meeting in New York of the United Nations Commission on the status of women.

Reciprocity

The long-awaited goal of nationwide reciprocity for nurses looms nearer with the announcement that, as of January, 1951, the same licensure examinations will be given in 48 States, the District of Columbia, the Territory of Hawaii, and British Columbia. Candidates for licensure are also reminded that some states permit graduate nurses to take licensure examinations outside the state in which they are seeking licensure.—*R.N.*, Mar. 1951.

Improved Nursing Service

St. Louis University School of Nursing will offer a graduate major in administration of nursing services beginning with the fall semester, 1951. This course is designed to prepare nurses for positions as supervisors and as directors of nursing services. The new program is an outgrowth of St. Louis University's participation in the research seminar at the University of Chicago. That seminar, financed by the Kellogg Foundation, was inaugurated by the Foundation as one step essential in providing improved nursing service.—*Hospital Progress*, Apr. 1951.

Central Nursing School

A central nursing school has been opened at the Catherine Laboure School by the merger of the schools of nursing of the Carney Hospital, Boston; St. John's Hospital, Lowell; and St. Margaret's Hospital, Dorchester. The new school will offer a three-year basic diploma course and has been approved by the Approving Authority of the Massachusetts State Board of Registration of Nurses.—*Hospital Progress*, Apr. 1951.

Briefs from WHO

An anti-malarial campaign on the south coast of Java is to be launched by the Indonesian Government. WHO is providing internationally recruited personnel and will set up a training centre for local malarial workers.

WHO, on request of the government of Viet-Nam, has begun a two-year demonstration of insect control methods for the fight against malaria and other insect-borne diseases.

The first demonstration area in the Americas, under the U.N. Technical Assistance Program, has been established in El Salvador.

Representatives of all WHO member states were invited to attend a three-week meeting in April to discuss new WHO sanitary regulations. The new regulations, designed to replace all existing sanitary conventions, will come into force next year throughout the world if accepted by the Assembly.—*WHO Newsletter*, Apr. 1951.

I.C.N. News

The I.C.N. hopes to be able to recommend to the Board of Directors, in August, the Nurses' Association of Trinidad and Jamaica for associate status. Spain and Northern Rhodesia have formed national associations. Luxembourg is asking for full membership and the nurses of Syria have organized themselves into an association and are applying for membership.

The finances of the Japanese nurses, who number 60,000, have improved to the point where they are now able to remit dues for 1950 and half-dues for 1951 to the I.C.N.

The executive secretary was in Geneva in April to represent the I.C.N. at a joint meeting of the World Health Organization and World Medical Association during their discussion on policies and plans for a national emergency and in May to attend the Fourth World Health Assembly. In March she visited Portugal at the invitation of the Portuguese Government to discuss nursing.

The I.C.N. has been able to secure additional office space at 19 Queen's Gate and has vacated the flat at 45 Gloucester Place which formerly served as offices for the F.N.I.F.—*I.C.N. Monthly Newsletter*.

Orientation et Tendances en Nursing

La Valeur de la Personne Humaine

Cette expression — la valeur de la personne humaine — que nous trouvons dans la Charte des Nations Unies est devenue une expression courante et je me demande parfois si par son emploi constant nous ne diminuons la portée des mots qu'elle renferme. Les derniers développements de la science sur la matière nous suggèrent une analogie qui vous aidera à réaliser tout le sens de cette expression.

La bombe atomique est la plus grande force explosive connue de nos jours. Tout de même, pour déclancher cette formidable explosion un seul neutron, une particule invisible, infinitésimale, faisant fonction de cannon, en a fait partir deux autres et ces deux-là encore deux autres et ainsi de suite, développant à la chaîne une force terrible presque capable de faire trembler la terre. Ce qui est vrai dans l'ordre physique l'est aussi dans l'ordre moral: l'action d'une personne, son rayonnement, peut en influencer une multitude d'autres. De la science moderne nous pouvons tirer une leçon — l'importance de l'infinitésimal et, par analogie, la grande importance de *la personne humaine* et la grande valeur de la liberté humaine. Il suffit qu'une personne, une organisation, un pays mettent à exécution une bonne idée pour que tout le monde devienne meilleur.— Sir Benegal Rau.

Coup d'Oeil Ici et Là

Les infirmières sont des personnes actives. Il suffit de consulter les journaux pour y lire quelque chose d'intéressant à leur sujet:

En Angleterre — Le Conseil de Comté de Derbyshire veut proposer de conserver à titre de monument historique à la mémoire de Florence Nightingale, la maison lui ayant appartenue à Holloway.

Au Nouveau Brunswick — Une suggestion fut faite au parlement d'accorder une aide financière aux étudiantes infirmières leur permettant de defrayer les dépenses de leur cours. Les infirmières de l'hygiène publique étudient avec intérêt le rapport Baillie-Creelman. Aux réunions du "Educational Policy Committee" (correspondant à notre Comité des Ecoles) l'on discute avec animation l'administration et le coût des écoles d'infirmières, les conditions d'admission, les cours universitaires, et les changements qu'il faudrait apporter dans la formation des infirmières. Les infirmières des hôpitaux se proposent de tenir des journées d'études par leurs hospitalières et les assistantes hospitalières.

A l'Ile-du-Prince-Edouard — Une série de bulletins sur la nutrition, intitulés "La Mode en Alimentation," nous parvint de cette petite province.

De la Colombie-Britannique — Dans cette province, l'Association des Infirmières Enregistrées est l'agent négociateur des infirmières. Lors de l'assemblée annuelle la secrétaire a fait connaître tous les services mis à la disposition des infirmières. Un cours sur

la défense en cas d'attaque atomique fut donné par Ferne Trout qui a suivi récemment à San Francisco un cours sur ce sujet.

Manitoba — La secrétaire générale de l'Association des Infirmières du Canada a adressé la parole à l'assemblée générale de l'Association des Infirmières Enregistrées de cette province. Son sujet était "Regards sur l'Avenir de la Profession d'Infirmières."

Québec — Chez les nôtres, l'importance de l'éducation du personnel est réalisée de plus en plus. Des professeurs de l'Institut Marguerite d'Youville (Université de Montréal) ont donné des cours en surveillance hospitalière aux infirmières de l'Hôpital St-Luc, de Notre-Dame, et du Jewish General.

Gertrude Dallaire, infirmière chef de groupe à la Section du Nursing, Service de Santé de la Ville de Montréal, vient d'obtenir un congé pour visiter les organisations sanitaires de France et de Suisse sur l'invitation de l'Organisation Mondiale de la Santé. Mlle Dellaire avait été prêtée par la ville, il y a un an, à l'O.M.S. pour du travail d'éducation en Haïti (*juin, 1951, page 426*).

Ontario—L'on nous rapporte de London que 16 infirmières ont completé le cours en nursing psychiatrique donné, pour la deuxième fois, conjointement par l'Université de Western Ontario et le Département des Anciens Combattants. Une conférence sur l'évaluation des services de l'infirmière diplômée fut donnée par Edith McDowell, doyenne de la Faculté du Nursing à U.W.O., lors de la conférence de l'Association des Hôpitaux de l'Ontario. Le conseil de ville de Port Colborne a voté deux bourses d'étude de $100 en faveur de jeunes filles des écoles primaires supérieures, désireuses de suivre le cours d'infirmières.

Les salaires dans les hôpitaux de la région de Kirkland Lake ont été augmentés. Les infirmières de la Société des Enfants Infirmes ont fait plus 200,000 milles dans 43 comtés et ont visité 4,591 enfants infirmes.

Alberta—A Lethbridge, les honoraires des infirmières du service privé ont été augmenté à $8.00.

UN MEILLEUR SERVICE EN NURSING

L'école d'infirmières de l'Université de St-Louis offrira un nouveau cours en administration hospitalière à l'automne. Ce cours est offert spécialement aux infirmières désirant se qualifier aux postes de surveillantes et de directrice du nursing. La création de ce cours a été jugé comme le premier pas nécessaire pour l'amélioration du service du nursing. L'Université de St-Louis participe avec l'Université de Chicago a des recherches sur les moyens à prendre pour l'amélioration des services du nursing sous les auspices de la Kellogg Foundation.

UNE ECOLE CENTRALE

Une école centrale vient de s'ouvrir a Boston sous le nom de "Catherine Labouré School of Nursing." La réalisation de cette école centrale a été rendue possible par la fusion des écoles suivantes: Carney Hospital, Boston; St. John's Hospital, Lowell; and St. Margaret's Hospital, Dorchester. La nouvelle école offre un cours de base de trois ans, donnant droit à un diplome. L'école a été approuvé par "Massachusetts State Board of Registration of Nurses."

NOUVELLES DE L'O.M.S.

Une campagne centre la malaria vient d'être lancée par le gouvernement de l'Indonésie. L'O.M.S. a recruté le personnel nécessaire lequel établira un centre d'entraînement pour les indigènes.

Le Gouvernement de Viet-Nam a demandé à l'O.M.S. de donner une démonstration sur le contrôle des insectes afin de combattre la malaria et autres maladies transmissibles par les insectes. Le démonstration durera deux ans.

La première démonstration en Amérique a eu lieu dans le Salvador.

CONSEIL INTERNATIONAL DES INFIRMIÈRES

Le C.I.I. espère, lors de la prochaine réunion du Comité de Régie, pouvoir recommander l'admission dans ses cadres de l'Association des Infirmières de Trinidad et de la Jamaïque à titre de membre associé. L'Espagne et la Rhodesie du Nord ont formé des associations nationales. Au Luxembourg et en la Syrie les infirmières demande à faire partie du C.I.I.

La situation financière au Japon s'est améliorée au point qu'il est possible pour les infirmières de ce pays de payer leur contribution au C.I.I. pour 1950 et la moitié de celle de 1951.

La secrétaire du C.I.I. s'est rendue a Genève en avril et en mai à la réunion de l'O.M.S. pour participer aux discussions sur les mesures à prendre en cas d'urgence. En mars le Gouvernement du Portugal demandait à la secrétaire du C.I.I. de se rendre dans ce pays afin d'y discuter le nursing

Dix infirmières d'Egypte suivent un cours post-scolaire de six mois en Angleterre.

D'IMPORTANCE CAPITALE POUR LES INFIRMIÈRES

A la quatrième réunion de l'Organisation Mondiale de la Santé, dans une discussion libre sur les différents aspects de l'éducation et de l'entraînement du personnel en hygiène publique, la secrétaire du Conseil International des Infirmières représentait les associations d'infirmières.

Le rapport de l'O.M.S. sur le nursing devait être discuté à New York en avril et en mai lors de la réunion de la Commission des Nations Unies sur le status de la femme.

RÉCIPROCITÉ

Un but que depuis si longtemps l'on cherche a atteindre, un enregistrement national par réciprocité va enfin être touché du moins aux Etats-Unis. Les mêmes examens d'enregistrements seront tenus dans 48 états, dans le District de Columbia, et dans le Territoire d'Hawaii et dans l'une de nos provinces — la Colombie-Britannique.

In Memoriam

Mayme R. Downey, who graduated from the Ottawa Civic Hospital in 1929, died there on April 16, 1951. Following graduation Miss Downey had served in various administrative capacities until 1944 when she was appointed director of the Veterans' Pavilion. She was a charter member of the Alumnae Association at the Civic, a past president, and first editor of the Alumnae publication.

* * *

Marie Galbraith, who graduated from St. Michael's Hospital, Toronto, in 1912, died on December 28, 1950. Miss Galbraith took post-graduate courses in public health nursing at the School of Nursing, University of Toronto, and at Toronto Psychiatric Hospital. She was on the staff of the Toronto Department of Public Health until her retirement in 1947.

* * *

Mary Frances Giblin, who graduated from St. Michael's Hospital, Toronto, in 1916, died in Toronto on February 21, 1951. Miss Giblin worked on the staff of her own hospital for some time, then went to the United States.

* * *

Charlotte Hanington, who was chief superintendent of the Victorian Order of Nurses for Canada from 1917 to 1923, died in Vancouver on April 27, 1951, in her 86th year. Mrs. Hanington was born in New Brunswick and secured her professional training at the Waltham (Mass.) School of District Nursing. She moved to B.C. in the late 1880's following her marriage and took a prominent part in women's affairs in Victoria for many years. She was a charter member of the I.O.D.E.

Under her direction, the Victorian Order of Nurses served faithfully during the Halifax Disaster in 1917 and the influenza epidemic in 1918. She guided the V.O.N. with a steady hand during the financial problems and staff shortages that followed World War I.

* * *

Arletta Hollingsworth, a graduate of the Winnipeg General Hospital, died in Kingston, Ont., on March 28, 1951, at the age of 75. Miss Hollingsworth spent much of her life working in the public health nursing service in Manitoba. She retired some years ago.

* * *

V. Pearl Payton, who has been head of the Salvation Army Social work in Canada and Bermuda since 1948, died in Toronto on April 26, 1951, at the age of 57. Lieut. Col. Payton received her nurse's training in London, Ont., and engaged in staff work in Saint John, N.B., and Windsor, Ont. She became superintendent of the Salvation Army hospital in Halifax then was transferred to Winnipeg where she was superintendent of Grace Hospital for 15 years. She then went to Grace Hospital in St. John's, Nfld., where she organized the school of nursing.

Carrie M. Robinson, who graduated from the Orillia (Ont.) General Hospital in 1913, died in Orillia on January 31, 1951. Miss Robinson was assistant superintendent at the Orillia hospital from the time of her graduation until 1920 when she went to Listowel, Ont., as the first superintendent of the hospital there. She retired in 1931.

* * *

Muriel (Anderson) Rowberry, who graduated from the Royal Jubilee Hospital, Victoria, in 1917, died in Chilliwack, B.C., on April 10, 1951, in her 59th year. Until her marriage in 1919, Mrs. Rowberry engaged in private nursing. Since then, though not engaged in active work, she had maintained a steady interest in her profession, being a busy member of the Chilliwack Chapter, R.N.A.B.C.

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Ledwina H. Servos, who graduated from Columbus Hospital, Seattle, Wash., in 1926, died in Hamilton, Ont., on April 16, 1951. She had been ill for three months. After serving as a supervisor in that hospital for some time, Miss Servos received her B.Sc. degree in public health nursing from the University of Washington. She returned to her birthplace, St. Catharines, Ont., several years ago and was an active worker in the Canadian Cancer Society and Canadian Red Cross Society. Miss Servos was president of the Graduate Nurses' Association of St. Catharines last year.

* * *

Charlotte Gillespie Smith died at Woodstock, Ont., on March 29, 1951, in her 81st year. After graduating from a Chicago hospital, Miss Smith spent a number of years working in mission hospitals in western Canada, notably in Winnipeg and Edmonton. She retired many years ago.

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Elizabeth Ann Thom, who graduated from Victoria Hospital, London, in 1911, died in Saskatoon on April 9, 1951, in her 73rd year. Following graduation Miss Thom accepted a position in Chicago. When World War I started she went overseas with an American Red Cross unit. She transferred to the nursing service of the C.A.M.C. in 1916. Upon her discharge in 1919, she returned to London but soon afterwards joined an American Near East relief project and was sent to Armenia in charge of a huge children's hospital. In 1923 she joined the staff of Westminster Hospital, London. Three years later she became chief nurse of Cook County, Ill., which included all of Chicago. She retired in 1940.

Nursing Conference and Exhibition

JEANNE M. BENOIT

One of the most illuminating and edifying professional gatherings that I have ever attended was held in London, England, October 23-27, 1950, under the auspices of the *Nursing Mirror*. Its official title was the "35th Annual London Nursing Exhibition and Professional Nurses and Midwives' Conference."

I felt greatly privileged as a visitor, to be admitted, as space was limited. Admission tickets had to be obtained beforehand and, surprisingly, there was no charge. A very complete guide-book was issued with the admission ticket, giving detailed information about everything one might wish to know concerning the conference. For example, there were complete directions, including a diagram and a list of the buses and underground trains, to assist in finding the way to Seymour Hall where the conference was held. Anyone who has visited London will realize what a great help this was. The booklet also contained a descriptive list of the stalls in the exhibition and the schedule of lectures and films, besides some useful general information for visitors to London. Many of the nurses who attended came from other parts of the country.

The exhibition consisted of trade stalls where different wares were exhibited in the main hall. The lectures were held in an adjoining hall where there were facilities for showing films.

The exhibition and conference was opened by the Countess Mountbatten of Burma (the

Duke of Edinburgh's aunt) who gave the inaugural address. She has had a vital interest in the nursing profession for many years and is actively associated with the Order of St. John of Jerusalem. She is also president of the Royal College of Nursing Educational Fund Appeal. The Countess quoted Sir Cecil Wakeley, president of the Royal College of Surgeons, who opened last year's conference. He said:

> It would be difficult to find another such program of post-graduate instruction, conducted by so many eminent members of the various branches of the medical profession.

The Countess added that post-graduate education of nurses was a subject very dear to her heart.

The conference could scarcely have had a more full and varied program. The difficulty was to try to accelerate one's brain to absorb such an abundance of information in such a short space of time.

About 50 per cent of the lectures dealt with obstetrics for the benefit of the many midwives present. The remainder were of a general nature, covering most spheres of medicine and surgery. Many of the lectures were accompanied by slides, which were of great assistance in clarifying the subject. Some of the titles were:

> The Allergic Diseases and the Antihistamine Drugs; Modern Treatment of Rheumatic Conditions; Recent Advances in Thoracic Surgery; Travel Sickness; The Problem of Deafness; Psychology of Early Childhood; Psychology of Old Age; Management of the Third Stage of Labor.

The last-mentioned lecture was delivered by a Canadian doctor, Donald B. Fraser, who is now on the staff of St. Bartholomew's Hospital in London. In every case, they were given by outstanding medical men—or women (two)—in their particular field.

I felt at the end of the course that I had been given an excellent review in anatomy, an outline of the most up-to-date treatment and many new ideas—with the explosion of some old ones—in the surgical, medical, and psychological care of patients. Questions from the audience could not, unfortunately, be permitted, due to lack of time.

Two interesting experiments that are being tried related to the very old and the very young. In one children's hospital, the child's mother is admitted with the child, if she desires it, and provided the hospital does not feel that her presence would be a deterrent to the child's progress. The hospital authorities feel that, normally, the mother's presence is an important factor in assisting the child's recovery. Also, the mother is educated there in caring for her sick child, who can often be discharged sooner than if he were returning home to uncertain treatment.

In another hospital, a geriatric unit has been opened for elderly people without families to care for them, where their mental condition is studied and treated. As the patients improve, emphasis on routine is relaxed and they are allowed to follow their own inclinations, in so far as they do not interfere with their treatment or the welfare of the other patients. Rehabilitation following discharge is part of the program and an old people's club has been opened in the hospital grounds to which an ex-patient may return at any time. The lecturers stressed the point that the geriatric unit was not a place for stagnation.

The doctor who lectured on Recent Advances in Thoracic Surgery described briefly some of the operations that could be performed for certain diseases of the heart and he said, "The last surgical frontiers have now been passed."

Interspersed with the lectures, some excellent films were shown. Several of the anatomical films and slides were of great value in familiarizing one with the appearance of the "inner man" or woman. The anatomical models, good as they are, and the "real thing" are so different in actual appearance that, I think, unless a nurse is engaged in operating theatre work, she is apt to be lost in a maze of muscles, tissues, and fibres, when viewing the inside of a body.

Apart from the above program there was the exhibition to visit whenever there was a spare moment between lectures and films. There were some 50 stalls, exhibiting many things of interest to the nursing profession. Various drug companies were represented, firms supplying hospital and nurses' equipment, firms publishing nurses' textbooks, invalid and baby food manufacturers, a series of posters depicting nursing in atomic warfare, a recruitment booth for the National Hospital Service Reserve (for call-up, should a national emergency arise), and a nurses' handicraft stall.

Quantities of literature and many samples were given away. With some of the drug and invalid food companies a nurse could leave her name and address in order to have samples of new products sent to her, as soon as they were placed on the market.

Some of the more unusual features of the exhibition were the following:

1. The "*Magbed*"—the latest invention in hospital beds, providing, as it advertised, a "full range of attitudes (10), obtainable with finger-tip effort by one nurse, as are minor adjustments possible for the convalescent patient himself." One nurse can manipulate the bed and patient into any position that might be desired, with little effort and from whichever side of the bed she happened to be at the time. The patient himself can raise or lower the head of the bed with ease.
2. "*Telenurse*"—a call system for installation in a hospital ward. It consists of an instrument box to be placed in the nurses' office, to which is attached a connection at each patient's bed. In this way, the nurse can save a trip, by finding out what the patient requires before going to his bedside. Constant communication with a very sick patient can also be maintained by keeping the connection open continuously. The nurse can then hear every sound that the patient makes, while sitting at her desk.
3. The *atomic warfare posters* showed how radioactivity in an area can first be detected with a specialized instrument; how radioactivity affects individuals and what the necessary first-aid measures and nursing care are. Human beings can be affected slightly, seriously, or fatally. An actual radiation detection instrument was being exhibited also.
4. The *nurses' uniform booth* displayed a variety of uniforms—from white ones, very similar to our own, to some smart models in navy, green, and maroon serge.
5. The *nurses' handicraft booth* showed the achievements in a popular pastime among English nurses. First, second, and third prizes were awarded for the handicrafts judged the best in each class. To me, every article appeared to be most beautifully and skilfully done. There was sewing, knitting, leatherwork, hooked rugs, needlework and embroidery of all kinds.

For the bodily needs, there was a catering service where one could purchase morning coffee, a substantial lunch, and afternoon tea. Finding the time to partake of these repasts was the problem, because if one attended the five lectures and two films (each lasting about three-quarters of an hour) daily, as I did—and tried to visit the exhibition besides—there was little time left for anything like eating! This gave an opportunity, however, of proving the true value of the "energy-giving" foods and beverages. When weak with hunger, one could hastily consume a biscuit or hot drink or take a tablet to nibble, as one hurried past a stall.

The conference was well attended. Male nurses were in evidence at most of the lectures. There are many more of them trained in England than in Canada. The number of male student nurses accepted for training is steadily increasing. There were several visitors, some from as far away as India. There was a record attendance on the last day. Over 1,800 were there. I went to the conference as a complete stranger but soon felt at home as everyone was very friendly. One day I met Joan Bourne, who was at the Toronto University School of Nursing at the same time as I. Her father, Dr. Aleck Bourne, gave the first lecture of the conference—"Hemorrhage in Early Pregnancy." Miss Bourne is now on the staff of the *Nursing Times* and it was at her suggestion that I have written this article.

This is a brief sketch of a most valuable and worthwhile experience, which was my introduction to the nursing world of England

World Health Conditions

Extensive application of the recent advances in medicine and public health has strikingly improved health conditions throughout the world. Comparing death rates just before and after World War II, in 19 countries the rate has declined by more than 8 per cent and in 9 of these countries it has dropped 20 per cent or more.

Of marked significance are the declines in mortality recorded in the so-called underdeveloped and poor sections of the globe. In Japan the death rate fell by 30 per cent, largely as the result of public health measures instituted by the American army of occupation. Norway has the lowest death rate in the world.

Student Nurses

Rheumatic Heart Disease

MARNEY McLELLAN

Average reading time — 25 min. 36 sec.

INTRODUCTION

THIS IS A description of an atypical case of rheumatic heart disease but it shows how a diagnosis is made, what treatment is carried out, and the response to that treatment. Usually rheumatic heart disease follows a diagnosed case of rheumatic fever or runs concurrently with it. Some factors affect the incidence of rheumatic fever. Climate plays an important part, the disease being more prevalent in temperate climates. Crowded living conditions, exposure, and poor nutrition are predisposing causes. There is thought to be an inherited familial tendency or susceptibility. Rheumatic fever has a tendency to recur and relapse.

Joint symptoms are a prominent clinical feature of rheumatic fever. They become swollen, hot, and tender, particularly when moved, but there is no residual damage. A characteristic sign is the rheumatic nodules found on the affected joints, usually in children. Fever is usually moderate with the pulse accelerated out of proportion. Other symptoms are increased perspiration, increased fatigability, apathy, anorexia, and loss of weight. There may be a leukocytosis and a slight secondary anemia. The sedimentation rate is almost always increased.

Rheumatic heart disease may be active or inactive. In the active state there is involvement of every structure in the heart. A friction rub over the heart and fluid in the pericardium are common and indicate pericarditis. Myocarditis or involvement of the muscle layer is shown by the electrocardiogram. There is a prolongation of the PR interval. The presence of murmurs indicate endocarditis. The heart valves may be involved—first the mitral valve then the aortic. Stenosis and insufficiency follow valve involvement. In the inactive form of heart disease the patient has a history of joint involvement such as chorea or rheumatic fever and chronic valvular disease.

Chorea is usually considered as part of the symptom complex-rheumatism, endocarditis, chorea. It is a disease of young people, usually children, and more common in girls than boys. The onset may be rapid or gradual. The usual symptoms are spontaneous movements, ataxias, weakness, and psychic changes. Speech involvement may occur. The movements are involuntary, conscious muscular jerks and twitchings. Sensory stimuli increase the twitching. It seems to have some relationship to rheumatic fever in its incidence and resulting heart damage.

HISTORY

Linda is a little girl of five years who has had an active happy childhood. She is the youngest in a family of four—a sister is 20 and two brothers are 18 and 16. She talks and acts old for her age. Linda took a great interest in everything around her even when she was critically ill. During her stay in hospital she played happily by herself when left alone but always seemed glad to have someone talk to her and look at her gifts and cards.

Miss McLellan wrote this interesting nursing care study while a senior student nurse at the Vancouver General Hospital.

She appreciated anything that was done for her, particularly having her hair braided and tied with ribbons sent to her by her sister. She was a very cooperative child.

Linda is rather small for her age but is fairly well developed. Her appetite has always been only fair but during her present illness she has had no appetite at all. For the first few weeks she picked at her food and would eat only a little with persuasion. As she felt better her appetite increased. She is a very slow eater, taking much longer than the other children on the ward.

Linda appeared to be a well-cared-for child. Her bowels have always been regular. She has had plenty of rest and sleep—about 12 hours at night and a nap in the afternoon. Her teeth are in good condition and she has had no dental attention.

She was quite ill with a septic throat a couple of years before in 1947 and was treated with penicillin and sulfa for 10 days. At the age of three she had chickenpox but recovered with no disability. The following June she had a stomach ache, fairly mild periumbilical pain, which lasted for half a day. There was no vomiting. This same complaint recurred three or four times during that summer.

In August, 1949, she again had a stomach ache. This time the pain was more severe and was situated in the periumbilical region. This attack lasted for five days and Linda remained in bed voluntarily for that length of time. She had a fairly high fever (101°) but no vomiting. At this time she complained of a transient stiffness of her left arm. She was seen by the local doctor who found her abdomen clear and her heart sounds normal. On September 1, Linda complained of abdominal pain that was severe and ranged to the lower front of the chest, particularly on the left side. The pain was associated with shortness of breath which was relieved by remaining in a sitting position. She was again seen by the local doctor. She had a fever of 102°, pulse 128, respirations 24. Her abdomen was soft with no tenderness. She had a definite pericardial friction rub in the heart area and very harsh breathing sounds. Her blood pressure was 83/50. Her pulse varied in strength with her respirations. An x-ray was taken and a definite change in the shape of the heart was noted with enlargement and some pericardial effusion.

Linda was in a small rural hospital for nearly a week before she was transferred to the Vancouver General. At that time she was found to have some liver enlargement, her white count was 18,000 with polymorphonuclears 64%, her R.B.C. was 3.9 million, and her hemoglobin 60%. She had been given penicillin q. 3 h. and sulfadiazine but with little effect. Her doctor thought that with the history of sore throat, a rheumatic infection of the pericardium was possible.

FAMILY HISTORY

Linda's father had rheumatic fever at 12 years of age, followed by chorea. Her sister had had a septic throat at the same time as Linda. One of her brothers has had nasal hemorrhages since infancy. At the present time a cousin on her father's side is suffering from chorea. There is no diabetes or tuberculosis in the family. Linda has never had a Mantoux test.

Linda was admitted to the pediatric ward on September 8. She was a pale little girl having some dyspnea. Her general condition was good but she appeared listless and apathetic. Once or twice she cried out as if in pain but would not complain of any discomfort.

PHYSICAL FINDINGS

Linda's blood pressure was 90/40 and remained constant during her time in hospital. Pulse was 144, regular; respirations were rapid and irregular but she did not appear to be in any distress. Her tonsils were present but not inflamed. Her tongue was coated. The cervical glands in the neck were firm, small, and palpable. Her skin was hot and dry, temperature 101° by rectum. There was a cardiac dullness to percussion showing gross enlargement to the left. A loud harsh friction rub was present. The liver was enlarged half an inch. The spleen was not palpable. There was no edema or cyanosis present.

In the afternoon of the same day, her heart sounds were muffled and the friction rub was gone. There was a dullness to percussion in the lower half of the right lung. Heart rate was still 144, regular and rapid. She showed no edema or neck vein engorgement. Diagnosis: Acute pericarditis due possibly to tuberculosis, rheumatic infection, or non-specific infection.

September 9. Linda's respirations were still rapid but she was in no distress. There was slight neck vein engorgement. The infection was thought to be rheumatic in origin and salicylates were ordered. In the afternoon her temperature was 103°, pulse 140, apex 156. On every third to fifth beat there was a loud slapping sound of high intensity which sounded like an extrasystole. There was also a periodic increased pulse volume every few beats. The friction rub was again present. An electrocardiograph was done at this time and showed no extrasystoles but an irregular rate due to premature auricular beats. The E.C.G. showed some myocardial involvement, sinus tachycardia, and sinus arrhythmia consistent with pericarditis. The PR interval is probably prolonged for this rate. An x-ray was taken and showed the heart enlarged to right and left and a pulling out of the left cardiac border anteriorly, suggesting pleural-pericardial adhesions. A small amount of fluid was evident at the right base of the heart and both lung fields were clear.

September 10. Linda's temperature was down to 99.2°, pulse 120, and she was looking much better. An aspiration of 10 cc. of straw-colored fluid was done from the fourth intercostal space. The fluid was slightly murky but did not contain true pus. It jelled firmly immediately after withdrawal. There was no neck vein engorgement nor increased dyspnea. The T. B. Patch test which had been applied was negative and it was to be repeated using a 1/10,000 solution of old tuberculin. Even though Linda is so young, rheumatic fever was thought to be the possible cause of her heart condition.

September 12. Linda was much improved. Her pulse was down to 90 and her temperature 99.3°. The heart sounds were more clear although the pericardial friction rub remained in diastole. A fluoroscopic and radiographic x-ray was taken. The heart shadow was grossly enlarged in all directions with a triangular shaped appearance. Pulsations present were diminished and of poor amplitude. There was a small amount of fluid in both costophrenic angles. The diaphragm moved freely. The appearance of the heart was compatible with pericardial effusion.

September 13. Linda took a turn for the worse. Her pulse went up to 120 and 132 per minute but was regular. Her temperature stayed down. The heart sounds were muffled again and there seemed to be systolic and diastolic murmurs which were ill-defined due to the pericardial rub. All chest sounds were amplified by inspiration. There was more liver enlargement—about 3 c.m. It was felt that there was some heart decompensation and, if the signs increased, digitalis therapy should be started.

September 15. Another x-ray showed the heart shadow not as broad but still enlarged both to right and left. Contours suggested pericardial effusion. The bronchovascular markings of both bases were exaggerated and a small amount of fluid remained at the base.

September 16. Deterioration was definitely noted. Linda was rather puffy about the face, apathetic and listless. Her pulse was only 120 but her respirations were up to 50 or 60. There was no cyanosis but a dry grunting cough was present. There was no neck vein engorgement. Heart sounds were much clearer with no friction rub. Breath sounds were heard all over the chest except over the right front lung where the upper half of the chest was full of rales and the lower half had diminished breath sounds. There was dullness to percussion in this area. The liver was further enlarged. Later in the morning, Linda had improved a little except for her respirations which remained very rapid. There were now conclusive signs of decompensation: dyspnea, rales in the lungs, liver enlargement to 6 cc., cough. There was still no cyanosis. Digitalis was ordered with the use of diuretics. The salicylate therapy was continued but not more than 30 gr. a day were to be given. It was felt that Linda had angular failure due to rheumatic pancarditis and that, from the absence of increased pericardial fluid and of the friction rub, pericardial constriction was not the cause of her present congestive failure. Later, about 6:00 p.m., Linda was much brighter. Her apex beat was 120, respirations were down to 48, and rales were absent.

September 18. Linda was showing more improvement. Apex was 118, respirations were 48. There was slight pitting edema of the left foot.

September 19. Linda's apex count had fallen to 96. The liver was not palpable and respirations were 40. Up to this time she had had 10 gr. of digitalis and two doses of half a cc. of mercuhydrin with ammonium chloride t.i.d. An x-ray showed a decrease in heart size. The right lung field was uniformly increased in density, suggesting either a pneumonic infiltration or atelectasis of the right upper and middle lobes.

September 20. The puffiness of her face had completely disappeared and Linda looked much better. She was still in the oxygen tent but her respirations had fallen to 24. Her pulse was 90. The cardiac dullness was reduced and the chest was clear. However. there was a definite grade 3 systolic murmur present and the heart sounds were again muffled. These signs gave the impression of rheumatic valvulitis of the mitral valve. A second E.C.G. was done and it showed definite myocardial involvement. The prolonged PR interval (the interval from the sinu auricular node to the auricular ventral node) was suggestive of acute rheumatic heart disease.

September 23. Linda was very much improved and playing happily in bed. She was now out of the oxygen tent and had no dyspnea. There was no evidence of edema or liver enlargement. Her pulse was 84. There was a definite grade 3 systolic murmur still evident. It was loudest at the apex. A questionable diastolic murmur was also heard at the apex.

September 27. Linda continued to show gradual improvement in pulse and other signs of decompensation. Pericardial effusion seemed much less as shown by a decreased heart size in the x-ray. The heart was within normal limits and both lung fields were clear. There was a residual endocarditis evident in the long systolic and short diastolic sounds.

September 29. For several days Linda's pulse had been 72. The grade 3 systolic murmur at the apex was now heard all through systole. The diastolic sounds were short and like a duplication of the second sounds. Linda had developed a cold and had slightly enlarged cervical glands. She was still on digitalis gr. ½ and salicylates.

September 30. Diastolic sounds were now inaudible and the systolic murmur was less intense.

October 3. During the rest hour while the ward was quiet, a definite systolic murmur of grade 2 or 3 was heard. It was of greatest intensity at the apex and at the third intercostal space 4 cm. from the midline. There was a suggestion of either roughening or a very short faint pre-systolic sound. The diastolic sound was no longer heard.

October 12. Another E.C.G. was done and it showed marked improvement with no myocardial involvement and a normal PR interval.

October 23. Linda was discharged to her home where she was to have three months' bed rest with a gradual rehabilitation following. A rather harsh systolic murmur at the apex remains. Her ultimate diagnosis was mitral stenosis.

LABORATORY FINDINGS

During Linda's 46 days in hospital she had almost daily urinalyses. At first the specific gravity was high, ranging from 1.025 to 1.035. After her condition improved the specific gravity dropped to range from 1.010 to 1.024, with one or two exceptions. The specific gravity measures the amount of solid material in urine in relation to the amount of water present. The normal for a child ranges from 1.008 to 1.020. The pH was 5.5 on admission and remained acid except in four specimens when it was 7 (neutral) or 7.5 (slightly alkaline). During the acute stage of her illness, some albumin and acetone were present, ranging from a trace to plus 3. At times some epithelial cells and

W.B.C. were found. As they disappeared after October 5, there may have been some kidney damage due to her heart condition. Traces of hyaline casts and reducing substances were found with uric acid and phosphorous crystals during the acute stage.

On admission, Linda's blood morphology was as follows:

Hemoglobin 65%, R.B.C. 3,470,000, W.B.C. 17,700, polymorphs. 67%, staff 15, lymphocytes 5%, and sedimentation rate 115 mm. per hour. Hemoglobin is normally 80% with the R.B.C. 4.5 million. W.B.C. normally range from 5,000 to 10,000, polymorphs. from 60 to 70% of the W.B.C., lymphocytes 25 to 33%, and no staff present. The sedimentation rate normally is 1 to 15 mm. per hour. A high sedimentation rate like Linda's is usually a sign of rheumatic fever. On *September 12* a second blood specimen showed her hemoglobin up to 62%, W.B.C. down to 7,150, polymorphs. 37%, lymphocytes 20%, and staff 25. The next test on *September 16*—W.B.C. 9,000, hemoglobin 75%, polymorphs. 67%, lymphocytes 23%, and staff only 8. On *September 19* hemoglobin was 78%, R.B.C. was up to 3,600,000, W.B.C. 8,900, polymorphs. 52%, lymphocytes normal, and no staff. The sedimentation rate had dropped to 73 mm. per hour. On *September 24* the W.B.C. was 10,450, hemoglobin 80%, and the sedimentation rate down to 32 mm. per hour. On *October 1* W.B.C. were 8,500, hemoglobin 79%, and the sedimentation rate only 22 mm. per hour. On *October 11* the last blood test was taken and showed the hemoglobin 80% and the sedimentation rate 8 mm. per hour.

The nose and throat swabs and vaginal smear taken on admission were negative. Blood cultures were done on September 10, 14 and 20 and in all cases there was no growth. The pericardial fluid was cultured and no growth appeared. In direct smears there were no organisms present.

NURSING CARE

After the routine admission Linda was made comfortable in bed. She was placed in an oxygen tent to help relieve her dyspnea. Care was taken to keep the tent tucked in well to give the greatest concentration of oxygen. Linda's dyspnea continued in spite of this treatment. A transfusion was ordered and a specimen taken for cross-matching and agglutination.

Penicillin, 50,000 units aqueous, q. 3 h. was ordered to help overcome any infection but was discontinued on *September 12* when S.R. penicillin 200,000 units daily was substituted. Intramuscular injections are given into the upper outer quadrant of the buttocks where there is less danger of hitting large nerves and blood vessels. Codeine, gr. ¼ by hypo, was ordered for discomfort but not given as Linda did not complain of any pain. Once or twice she cried out but when questioned would not admit having any pain. Phenobarb. gr. ½ was ordered and given whenever necessary for restlessness. Magnolax and a light diet were ordered.

Sodium salicylate, gr. 5 with soda bicarbonate gr. 5, was given q. 4 h. day and night as ordered. Salicylates have a specific action in rheumatic fever. This dose was increased to gr. 10 every second dose on *September 9*. Salicylates are very toxic to the body and, while being given, toxic symptoms of dizziness, ringing in the ears, deafness, and very profuse perspiration should be watched for. The treatment, if toxicity develops, is to decrease the dose to below the tolerance level until the symptoms regress. Soda bicarbonate is given with salicylates to help overcome pain in the stomach, nausea and vomiting which often result from its irritation of the stomach lining. When salicylates are given in large doses, acidosis may occur and soda bicarbonate helps neutralize the salicylic acid which forms in the stomach. On *September 11* the order was changed from sodium salicylate to aspirin (acetylsalicylic acid) of the same dose. This was done because of the involvement Linda was showing. Aspirin is also absorbed more slowly from the intestine and its effects are more lasting. It is not so apt to cause toxic symptoms. On *September 14* Amphojel was ordered to be given with the aspirin. Linda had been nauseated and vomiting after meals. The aspirin was withheld on *September 15* for one day then gr. 5 was given q. 4 h. with the Amphojel. Syrup of codeine dr. 1 was given to relieve the dry grunting cough Linda developed as heart involvement became more pronounced.

At this time Linda was on complete bed rest, being fed as well as bathed by the nurse. She much preferred to feed herself and at times seemed to be quite upset because she had to be helped. As soon as possible she was allowed to feed herself again. Linda's bed was kept in fairly high Fowler's position while she suffered from dyspnea. Care was given to the back with alcohol rubs and to the mouth using Dobell's solution. The oxygen was turned off and Linda was taken out of the tent for a short time while the alcohol was in use.

On September 16, definite signs of congestive heart failure were evident and digitalis, gr. 1 q. 6 h., was ordered. Each time before giving digitalis, the apical beat must be taken. Digitalis has three main actions:

1. It depresses the pacemaker, causing the heart to beat more slowly.
2. It depresses conduction in the heart muscle, sinu ventricular node, and bundle of His, causing a slower heart action.
3. It stimulates tone and contractility of heart muscle, causing a stronger contraction.

Digitalis has a cumulative action and toxic symptoms must be watched for. These are persistent nausea and vomiting, diarrhea, pain in the abdomen. Coupled rhythm and a slow pulse, one below 60, are signs that should be watched for. If the apex is below 60 the drug should be withheld until further orders. On September 19, Linda's order was decreased to gr. ½ b.i.d. for two days then a maintenance dose of digitalis gr. ½ daily. As signs of congestive failure gradually disappeared, Linda's pulse became slower. On October 4, the order was changed to digitalis gr. ½ daily, except Saturday and Sunday. On October 7, 8, and 9, Linda's apex count was below 60 and the drug was not given. On October 10, it was discontinued.

Mercuhydrin, ½ cc. intramuscularly, was ordered on September 16 and 18. Mercuhydrin is a mercurial diuretic and is usually used to increase urinary output and so decrease edema. Mercurial diuretics are usually given with a saline diuretic but due to nausea the ammonium chloride was withheld until September 17. This order was discontinued on September 25 when Linda was showing definite improvement.

Around September 20, Linda began coming out of the oxygen tent for an hour at a time. By September 23 she was able to remain out permanently. Ferrous sulphate gr. 5 with supper was ordered on September 23 to overcome Linda's anemia. This was to be increased to gr. 5 b.i.d. after two days if there was no nausea or anorexia. On October 4, the aspirin was decreased to gr. 5 four times daily and oral penicillin, which had been ordered on September 24, was discontinued. Supplavite was also ordered to help build her up and to supply vitamins. Enemas and magnolax were given when necessary to keep her bowels open.

On September 16, Linda was put on a low-salt, light diet. This means that foods are cooked without the use of additional salt and the trays go out without salt and pepper shakers. This treatment is designed to cut down the sodium content in the tissues as it holds the water there and causes edema. In a light diet some foods hard to digest, such as ham, salmon, pork, and corn, are not given. The dietary principles applicable in diseases of the heart are as follows:

1. Avoid bulky meals and prevent distension of the stomach. The stomach is close to the heart anatomically and distension would interfere with the heart action.
2. Avoid constipation.
3. Avoid foods such as concentrated sweets, members of the cabbage family, dried peas and beans, all of which ferment easily and may cause gas in the alimentary tract.
4. Avoid stimulants such as tea, coffee, and alcohol.
5. Avoid overeating and an increase in weight, both of which throw an extra tax upon the heart and blood vessels.

6. Avoid any foods known to be difficult to digest.

7. Fluids are given and salt is restricted as ordered by the doctor. In a salt-free or a salt-poor diet, protein and calories are maintained at the usual level, protein 50 gr. and calories 1,200-1,500 for a five-year-old girl. Fluids are given as ordered. In this case they were allowed as desired. Easily digested foods are used. Meals are small and frequent if possible. The vitamin-B complex should be abundant in the foods used. Foods allowed are: all cereals prepared without salt, both cooked and prepared, soda crackers without salt, salt-free bread and butter, all vegetables, fresh and canned, prepared without salt (except gas-forming ones such as cabbage, cauliflower, turnips, radishes, Brussel sprouts, cucumbers, and dried peas and beans), meats, fowl, fresh meat and fish prepared without salt, meat substitutes, eggs and cheese prepared without salt, desserts allowed on regular diets, milk, cream, fruit juices, jelly and honey. The foods avoided are: salt, spices, soups, cured meats or fish, cheese unless salt-free, and the gas-forming vegetables.

The salt-free diet was discontinued on October 7 when the signs of cardiac failure had completely disappeared. Linda took her diet very well although her appetite was not good. She always took a long time to eat but, if given time, she would manage to finish her meals. At one time she was nauseated due to the effects of the salicylates. This was overcome by the use of Amphojel.

During Linda's stay in hospital the usual child health teaching was given—e.g., bathing, brushing teeth, combing hair, regularity. She was kept as quiet as possible and given toys which would keep her occupied and happy but would not cause too much excitement. Linda was discharged on October 23 to her home where she was to remain in bed for an additional three months after which a gradual rehabilitation to a more normal life would begin. It was suggested that she be put on prophylactic sulfa during winter months and penicillin whenever necessary to prevent infection.

CONCLUSION

Linda's case is atypical as she developed a rheumatic heart condition without a definite case of rheumatic fever. The history of septic throat and transient joint pain later might possibly have some bearing on the case but is questionable as the heart involvement usually follows within a period of weeks. The familial incidence is shown, however. The dramatic response to salicylates with no response to penicillin and sulfa is typical of a rheumatic condition. As Linda progressed to decompensation most of the cardinal signs and symptoms developed—e.g., dyspnea, enlarged liver, neck vein engorgement, cough, enlarged heart, edema, rales. When digitalis therapy was started Linda showed remarkable improvement, proving the value of digitalis in congestive heart failure.

In Our Mail

Dear *Editor:*

This is to inform you of my change of address . . . I wouldn't want to miss one copy of our magazine. It sure helps to keep me up on current events in the nursing field. Even if I never practise again, I shall always be interested. I do miss your "℞ Chuckles P.R.N." (I must confess my husband does, too!)

—E.P.C., *Ont.*

Dear *Editor:*

I wonder if you have already been deluged with letters pointing out an error in the April edition of *The Canadian Nurse?* If you have you can ignore this letter.

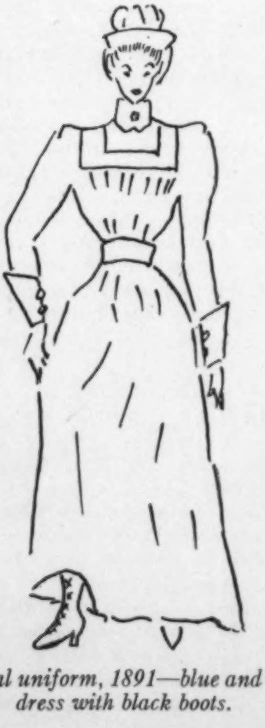
I couldn't resist pointing out that on page 265, at the top right-hand column, the writer refers to symptoms of cholecystitis, among them "*left* shoulder pain." I checked my facts and it is still the *right* shoulder!—M.R., *B.C.*

Reunion Time at Royal Jubilee

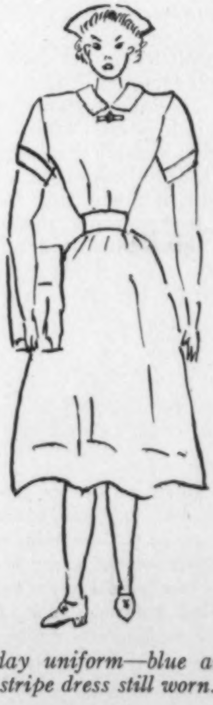
"On Wednesday, December 16th, 1891, was inaugurated the first school for nurses to be established in this Province. It will be conducted upon the system generally in vogue in other large cities, the pupils working under the Hospital Doctors and Nurses, and listening to lectures upon various branches of their profession by the Medical Board. The course covers two years. The first class at the Hospital, composed of five young women, occupied front seats in the Board Room during the proceedings of inauguration." So reads an abstract from the newspaper's description of the "Inauguration of the Training School for Nurses," written 60 years ago.

It was to celebrate the founding of their school of nursing at the Royal Jubilee Hospital that graduate nurses met last month in Victoria, B.C. They came from many parts of Canada to renew friendships and recount experiences of the past. In the four days allotted to the reunion—from May 31 until June 3—they were given opportunities to observe the growth of their hospital and school of nursing.

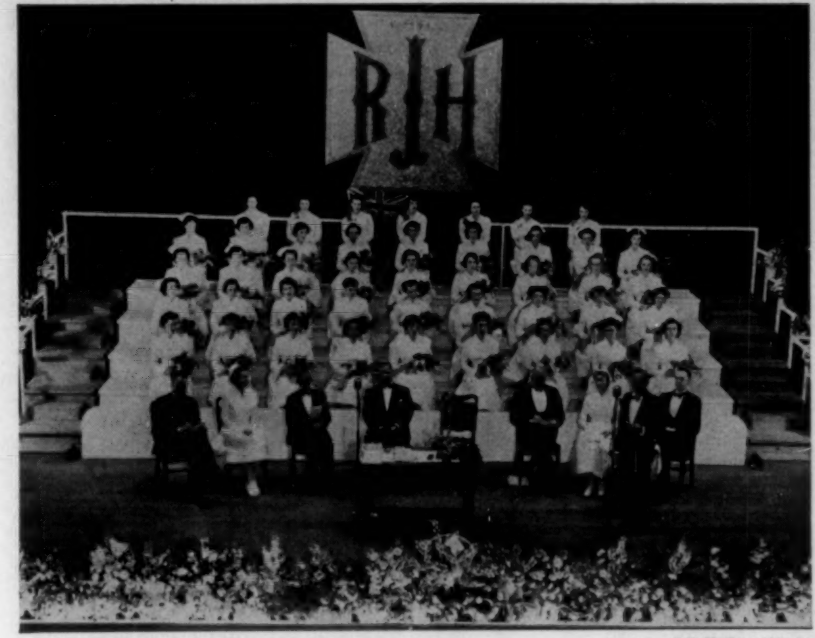
The first day commenced, as all reunions do, with a registration coffee party. Miss M. Plunkett, the president of the Alumnae Association, gave a welcome to all who attended. The afternoon was spent with the graduating class, at a tea given by the Alumnae Association. As guests of His Honor, the Lieutenant-Governor and Mrs. Wallace, the nurses were invited to tea at Government House the following afternoon and that evening met for a reunion banquet. The highlight of the next day was a tour of the hospital, conducted by the student nurses. This was accompanied by displays of historical interest and of present-day activities, shown in the classrooms. With graduation day of the 1951 classes falling on the closing day of



Original uniform, 1891—blue and white dress with black boots.



Present-day uniform—blue and white stripe dress still worn.



Bill Halkett, Victoria

Graduation, Royal Jubilee Hospital—1950.

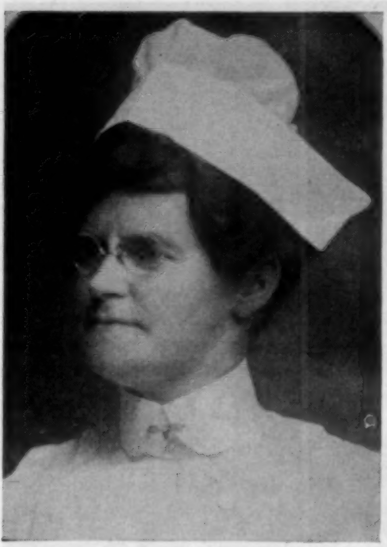
the reunion, the visiting nurses attended the Baccalaureate Service at Christ Church Cathedral. That evening, as the 53 members of the graduation class rose to receive their diplomas, each graduate in the audience felt a sense of pride in the realization that this school had grown from a class of five student nurses.

The story of our school, the first to be opened west of Winnipeg, is impossible to tell without first considering the birth and growth of the Royal Jubilee Hospital. It was on a night in 1858 that Rev. Edward Cridge, the first chaplain to this city with the Hudson's Bay Company, found a sick man who had been left inside the parish gates of Christ Church. With this discovery came the realization that some form of organized care for the sick must be developed. The community was growing rapidly in size as the stories of gold, furs, lumber, and other wealth to be found in the province reached the ears of the world. The first attempt at some form of hospital-like care was in a wooden building, the home of one of Victoria's citizens. This was abandoned after one year because Indians in search of food not infrequently gained entrance to the hospital through the paper-thin walls. The next venture was successful. It consisted of two buildings—one situated on what was then part of the Songhees Indian Reserve to house the men and the other in the town to care for the women.

The Duke of Connaught, on tour in Canada in 1890, was present in Victoria to open the Provincial Royal Jubilee Hospital—a red brick "U-shaped" building of 50 beds which was to form the foundation for the present 511-bed hospital. Here commenced the story of the training school, with Miss Summerfield as the first supervisor of nurses.

The education of the nurses was provided through the kindness of the doctors of that day and through their ability to observe and learn while on duty. Upon entering the training school, the new candidate was immediately introduced to floor duty. There, in her toe-touching uniform with high, starched collar, long sleeves, black cotton stockings and high-button boots, she tended the patients and the fires for many hours of the day and night, having only a hand-lamp to light her way.

Mrs. Bullock-Webster of Victoria is the only living member of that first class. She remembers and recounts for the nurses of more recent training the details of the nursing



JESSIE MACKENZIE

of those days. "One thing stands out in my mind," she relates, "and that was the smallpox epidemic of 1892. The Jubilee Hospital took over the care of the patients in a quarantine area consisting of rough board buildings and tents and shacks for sleeping quarters. Our fence was decorated with yellow flags. It was amusing to watch people drive on the other side of the road when passing, while we were lifting and nursing all the time. Our only protection was being vaccinated and I think that proves its effectiveness as not one nurse or employee took the dread disease."

Nurses of that day lived eight to ten in a room—what we today would call apartments. Then, about the year 1909, accommodation was found in the hospital building.

In a demonstration room at R.J.H.

Today the students live in a modern 200-bed residence. It is interesting to note, in interviews with nurses of that day, that there was no formal graduation ceremony at the end of the three years of training. It was marked only by the recognition of the completion of a time contract. This gradually developed to an informal gathering and the receiving of graduates' pins. Today there are two important events in the life of a student nurse. The first is the capping ceremony, instituted in this hospital by Miss Lucie Woodrow, the present director of nursing. At it, the probationer recognizes the completion of four months of preliminary training with the receiving of her cap from Miss Woodrow. The second is the graduation week, marked by teas, a dance, gifts, and congratulations from relatives and friends. This is climaxed by the ceremony itself.

The Alumnae Association was started by Miss Jessie MacKenzie, supervisor of nurses from 1914 until 1927. She laid the foundation for what is today an active group of graduates whose activities include providing bursaries for post-graduate study, entertaining student nurses at functions marking their advancement, and providing the link between the individual graduate and the Registered Nurses' Association of British Columbia.

The school of nursing of today provides well for the students. Through its lecture rooms, laboratory, diet kitchens, library, and demonstration rooms the three years of hospital duty are augmented by complete first-hand education at each step.

It is hoped that those of our graduates who were unable to be with us for this gala reunion will be present when we gather again at the 75th Anniversary—not too far away—and that all nurses everywhere who have read this article have enjoyed the short story of our school and its growth.

Nursing Sisters' Association

Arrangements for a picnic were completed when the *Saint John (N.B.) Unit* met at Lancaster Hospital, with Sarah Miles, president, in the chair. The resignation of Mrs. W. E. Riley as corresponding secretary was regretfully accepted. Mrs. Riley is leaving the city to reside elsewhere. A social hour was enjoyed and refreshments were served. The next meeting will be in October.

Golden Jubilee

The year 1951 marks the 50th Anniversary of the Royal Columbian Hospital School of Nursing.

Situated on the banks of the Fraser River, in the city of New Westminster, this hospital has the distinction of being the oldest on the mainland of British Columbia. In fact, there is much dispute as to whether it may not even be the oldest in the whole of the province.

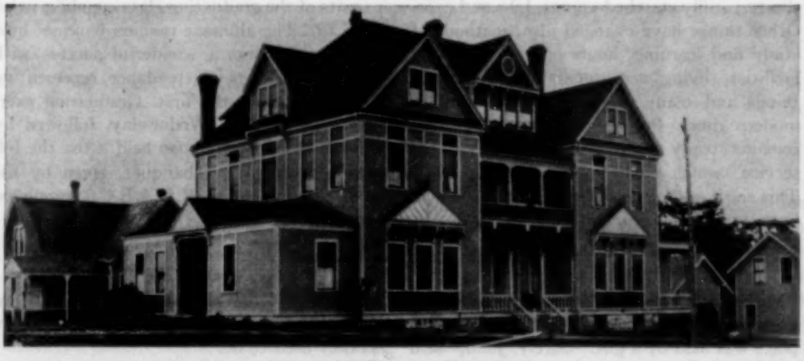
History reveals that in the year 1858 a company of the Royal Engineers, with their wives and children, set out from England in the clipper ship *Thames City*. After a trip involving some 186 days and many hardships, they landed on the shores of the Fraser on the site where now stands the Provincial Penitentiary. These hardy people had set sail with the express purpose of colonizing the then new land.

In the group was a certain Dr. Seddal, who jealously guarded several large oak chests. These chests were bound with iron bands and contained medical supplies which had been carefully collected and packed. Dr. Seddall set up the first hospital in a rude log hut. The chests, one of which lies in the vault of the present hospital, supplied the equipment and medicines necessary to care for the people in the colony.

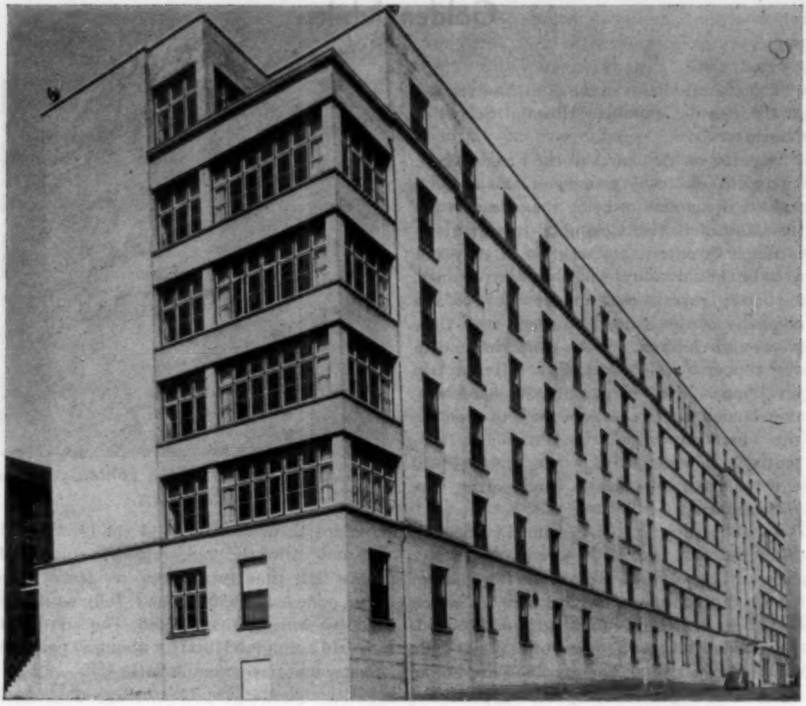
The actual hospital site changed places several times as bigger and better buildings were made available. Finally the present location was decided upon and in 1889 the first building was erected. Several other small wooden structures followed, such as a maternity cottage, a nurses' home, and three isolation cottages. Then in 1912 the brick building, now called the "old wing," was completed. Since that time two nurses' residences have been added. In 1950 the new, fully equipped, modern wing was completed. The first building had accommodation for about 30 patients; the present one accommodates 430.

Students examining the contents of the oaken chest.

Although the hospital's history dates back to 1858, it was not until 1901 that the first class was enrolled in the school of nursing. One student registered that first year: by 1910 there were 22 in the school. Today new class enrolments number forty-odd, with a total of 150 students at present in training. With the new improved facilities now available there is every indication that these numbers will increase further. In the last 50



1889—First building on the present site.



Croton Studio, New Westminster

The latest addition—1950.

years a total of 821 nurses have graduated.

There have been many changes since 1901. The school uniform is still a blue dress with white apron and bib but there is a sharp difference between those worn today and in that distant yester-year. It is mainly the difference between long, full skirts and quaint caps and shorter, stiffly starched aprons, bibs and caps. Other things have changed also: methods of study and learning, hours of work, working facilities, living accommodation. All these things and many more bear the stamp of modern times. Perhaps the only thing that remains steady and constant is the "spirit of service" which shone very brightly in 1901. This spirit, although the modern girl tends to keep it partly hidden, still shines.

Plans were made to make this anniversary memorable. With the Alumnae Association in charge of the arrangements, graduates from near and far were on hand for the festivities which took place the week of graduation—April 22 to 28. The opening affair was the dance on Monday evening. Tuesday, the parents of the graduating class members came for a tea. The alumnae reunion banquet held that evening was a wonderful success with over 250 members in attendance, representing every class since the first. Graduation exercises were held on Wednesday, followed by a reception. The alumnae held a tea the following afternoon. A banquet, given by the local chapter of the R.N.A.B.C., completed the gala events.

A small boy returned from school and told his father that he was second in his class. Top place was held by a girl. "Surely, John," said the father, "you're not going to be beaten by a mere girl." "Well, you see, Father," explained John, "girls are not nearly as mere as they used to be."

—*Independent Forester*

The Seamy Side of Travel

(*Continued from page 504*)

washroom. Fortunately, I headed for the right one. Once out in the corridor I adopted a refined degree of acceleration so as not to arouse suspicion. Arriving, I sat and pondered—"Here I was dealing in subterfuge and about to be caught red-handed!" I remained so long that several people came clamoring at the door, with likely more legitimate reason than I. However, each time that happened, I attempted to imitate our complete unit of eight Casualty Clearing nurses in the bathroom at the one time, with necessary sound effects.

Realizing I could not remain there for the duration, I opened the door, slid through and wended my way back. Here, to my amazement, was my conductor friend sitting in my seat (at least a third of it was mine!). He rose and said so kindly, "I have saved your seat, Sister." Smiling weakly, I thanked him and, with legs about to collapse, I sat down. Then, "May I see your ticket, Sister?" Blushing to such an extent as to prove guilt, rather than ignorance, I produced my third-class ticket and stutteringly said I was new in the country. He was nice. So nice, the thought flashed through my mind, "I must sometime travel to Scotland and stand all the way in retribution." Amid the silence which seemed to prevail, I produced the difference and was given a first-class ticket. It was a great feeling to really belong!

Finally we pulled into London. Now I began feeling in all pockets for the costly ticket to produce at the gate. Woe is me! In my fluster, what I had done with it I did not know. Anyhow, I could not find it. The coach emptied and there I was, still on hands and knees, searching under seats and in cracks, but with no success.

By this time, I was beginning to wonder if I would ever arrive at the Red Cross Nurses' Club or land in jail. Just then an old Cockney appeared at the door of the compartment, fully equipped with broom and duster.

By now my distress was sufficiently pronounced as to arouse the old chap's sympathy. I waited while he swept the dirt into the corridor, which we sifted through by hand, finding no ticket. Finally, the old man said, "Come, Sister, I'll let you out the back way." So my friend, and indeed he was a friend, picked up his broom and they both accompanied me out through the back gate.

It was not until two weeks later that I found my ticket. It had gone through a hole in my pocket and fallen to the bottom of the coat in the lining. So! On my next trip to London I bought a penny platform ticket, got myself through on to the train, sauntered nonchalantly through the front gate at the other end on my "much used" ticket.

Book Reviews

The Low Fat, Low Cholesterol Diet—What to Eat and How to Prepare It, by E. Virginia Dobbin and associates. 371 pages. Published by Doubleday Publishers, 105 Bond St., Toronto 2. 1951. Price $3.45.

Medical studies have demonstrated that there is a definite relationship between cholesterol intake and high blood pressure. Moderate reduction in the amount of foods containing cholesterol has no apparent effect upon the blood pressure whereas lower levels can be reached by rigorously restricting the intake of both fat and cholesterol. Such a diet means that nothing containing egg yolk, butterfat, animal fat or organ meats can be eaten.

It is simple enough to say what not to eat.

The problem arises in planning a palatable and nutritious diet excluding completely egg yolks, whole milk and butter. This new book will be of immense assistance to any person confronted with this problem. Prepared by a group of five food experts, it is primarily a recipe book and many very interesting recipes are to be found there—everything from soup to dessert. Many foreign recipes are included with special attention being directed to the use of flavorings and spices. Marshmallow sauce is proposed as a substitute for whipped cream, for example.

Beneath each recipe is found a table giving the "single serving" quantity of fat, cholesterol, protein, carbohydrate, and calories. If a low sodium diet is also required, there is a chapter that will be of assistance here, too. The biggest advantage stemming from the wide assortment of recipes is that the foods are amply nutritious for the whole family so that the labor and boredom of preparing special diets for one person are eliminated.

Study Guide Testbook in Anatomy and Physiology, by Carolyn E. Gray, M.A., R.N., Caroline E. Stackpole, M.A., and Lutie C. Leavell, M.A., M.S., R.N. 107 pages. Published by The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 6th Ed. 1950. Illustrated. Price $2.25.

Reviewed by Genevieve Wahl, Educational Director, School of Nursing, St. Paul's Hospital, Vancouver.

In reviewing this book, I found the main purposes to be: (1) to serve as a study guide for students, in the preparation of lessons; (2) to serve as a testbook for teachers to use in conducting written quizzes.

To develop these purposes the authors have compiled 107 pages of exercises which can be used for review by the students or as a time-saving factor in the preparation and presentation of examinations by the teacher.

These exercises consist of a large number of questions and statements in objective form. The student's answers are indicated by marking the correct response in some prescribed way. These questions and statements do not include all textbook detail but rather emphasize selected principles and facts.

Since the primary responsibility of the teacher, in bringing about a maximum degree of achievement in learning, has many problems in evaluation and measurement, I feel this book does much to aid in discovering the student's level of information in anatomy and physiology with more impartial results than by other methods of testing. The tests appear to measure a knowledge of the subject and give a real indication of the anticipated outcome. The clear directions, specific purposes, proper wording, and mechanical make-up of the material involved should make it a valid and reliable means of evaluating progress.

The reliability of the tests cannot be determined by examining the book alone. It must be determined by application and by statistical computation, which is in progress and cannot be reported on as yet.

Nutrition in Health and Disease, by Lenna F. Cooper, B.S., M.A., M.H.E., Sc.D., Edith M. Barber, B.S., M.S., and Helen S. Mitchell, A.B., Ph.D. Associate author, Henderika J. Rynbergen, B.S., M.S. 744 pages. Published by J. B. Lippincott Co., Medical Arts Bldg., Montreal 25. 11th Ed., revised and reset. 1950. Illustrated. Price $4.00.

Reviewed by Margaret Lang, Director of Dietetics, University of Alberta Hospital, Edmonton.

This book has been prepared with special consideration for the needs of student nurses. The order and treatment of subject matter conforms closely with the "Manual for Teaching Dietetics to Nurses" published by the American Dietetic Association in 1949. The book is a valuable reference for the graduate nurse, the dietitian, and the homemaker. It would also be useful to the public health worker in the teaching of nutrition in the homes. There is a good chapter on meal planning and marketing.

In bringing this book up to date, information of current international interest has been included. In the United Nations there are three organizations which are concerned with food—the Food and Agricultural Organization, the World Health Organization, and the United Nations Education, Scientific and Cultural Organization. UNESCO selected "Food and People" as a major topic for study in 1950.

Several new tables are included in the tabular material. There is a new table for quick diabetic calculation and one which shows acidity and alkalinity of the common foods. These are not usually found in textbooks. There is a detailed list of references, some of which are early sources and others as recent as 1949.

UNIVERSITY OF TORONTO SCHOOL OF NURSING

Session 1951-52

I. The Basic or General Course in Nursing:

5 years (4⅔ calendar years) in length; leads to the Degree of B.Sc.N. and gives also a qualification for general practice in public health nursing; qualifies fully for nurse registration. The candidate remains as a student in her University School throughout the entire course (with practice in the wards of the surrounding hospitals). *Entrance requirement:* Senior Matriculation (Ontario Grade XIII).

II. Courses for Graduate Nurses: Entrance requirement:

Junior Matriculation (Ontario Grade XII). These are all one-year Certificate courses as follows:

A. Preparation for Hospital and Nursing School Service:

(1) *Clinical Supervision:* Preparation in administration, supervision and teaching as head nurse or supervisor in one of the following fields:

(a) Medical Nursing.	(d) Paediatric Nursing.
(b) Obstetrical Nursing.	(e) Psychiatric Nursing.
(c) Operating Room Nursing.	(f) Surgical Nursing.

(2) *Administration of Nursing Service:* General.
Planned with particular reference to graduate nurses who wish to prepare for the administration of nursing service.

(3) *Administration of Nursing Service:* Advanced.
Advanced study to follow the general course described above.

(4) *Nursing Education:* General.
A course for candidates who wish to prepare for teaching in schools of nursing.

(5) *Nursing Education:* Advanced.
For nurses expecting to take positions as directors of nursing schools, or other senior educational work.

B. Preparation for Public Health Nursing:

(1) General Course (Introductory).

(2) Advanced Course in one of the following:

(a) Administration and Supervision.	(c) Child Hygiene.
(b) Mental Hygiene.	(d) Tuberculosis.

III. A Special Arrangement for Graduate Nurses:

Whereas a candidate with Senior Matriculation standing may register in the Faculty of Arts of this University and complete the General course in Arts in 3 years, and, whereas some of the subjects of this General course in Arts are identical with certain subjects included in the above Certificate courses, it has been arranged that a graduate nurse who registers in this General course in the Arts Faculty may register at the same time in this School and, during the same 3 years, cover the requirements for the Certificate in one of the courses as described above, except that the courses in Clinical Supervision are not included in this arrangement.

For information and calendar apply to:

THE SECRETARY

News Notes

BRITISH COLUMBIA

CHILLIWACK

Mrs. M. Johnston, president, was in the chair at a recent meeting of Chilliwack Chapter when 60 members attended. A report was presented by Mrs. Barwell from the Local Council of Women concerning hospital insurance. The guest speaker was Dr. W. C. Thompson of Vancouver, whose topic was "Poliomyelitis."

Mrs. Johnston was chosen president at the annual meeting of the local Business and Professional Women's Club.

NANAIMO

At the annual meeting of Vancouver Island District, 98 nurses, representing the chapters of Victoria, Cowichan-Newcastle, Nanaimo, Alberni Valley, and Plateau, the guest speaker was Gertrude Hall, C.N.A. general secretary. Her subject was "Looking Ahead with the Nursing Profession." Miss Hall said that nursing had now reached a Centenary of Progress and should ally itself increasingly with national and international organizations.

Miss Hall mentioned the work of the Structure Study Committee and the survey being conducted by Dr. Pauline Jewett; studies sponsored by the C.N.A. on nursing education; and the Committee on Civilian Defence, on both national and local levels. Some hospitals are concerned enough to analyze their own nursing services. In such job analysis four main questions are used: (1) Why do we do a certain procedure? (2) Can we eliminate this? (3) Can it be changed? (4) Can it be done by machine? The use of panel discussions was urged to secure support of the public in considering problems which cannot be solved by nurses alone and represents a new pattern in health and nursing education.

Following adjournment, Nanaimo Chapter served refreshments and a social hour was enjoyed.

The following officers will serve during the coming months: President, Mrs. L. Caldwell; vice-president, J. E. Pearson; secretary-treasurer, Mrs. D. L. Lewis; councillors, K. Bailey, Mmes L. Caldwell, C. Macleod; representative to *The Canadian Nurse*, J. Ciceri.

NELSON

The annual meeting of West Kootenay District was held at the beginning of May when 85 members attended, representing the chapters of Trail, Rossland, Nelson, and Slocan. All groups reported an active year. Their chief project is to encourage girls to go in training by offering a bursary or monetary award.

Officers elected were: President, Nancy Lee; vice-president, E. Suran; secretary, S. Mollard; treasurer, Mrs. J. Barge; councillor, Mrs. M. Higgins; hospital and general nursing, V. Eidt; public health, R. Dunn.

PORT ALBERNI

A tea, put on by Alberni Valley Chapter in observance of Florence Nightingale Week, proved an outstanding success under the convenership of Mrs. J. Bateman. She was assisted by the president, H. Laycock, M. Dunbar, and other members of the committee. J. Bailey and Mrs. E. Miller acted as receptionists. Miss Pullen was in charge of a window display at Woodward's which attracted considerable interest in events marking the National Nurses' Week.

VANCOUVER

St. Paul's Hospital

The alumnae association extends a welcome to all the members of the class of 1951, particularly to Mr. Bullen, the first male member. Special congratulations are also in order to G. Warkentein who led the province in the R.N. examinations.

Joyce Collison, of the staff of Shaughnessy Hospital, attended a course on Nursing Aspects of Atomic Warfare held in San Francisco. Miss Collison and other Vancouver nurses who were present will be giving lectures for the benefit of members of the profession. Jean Todd is now nursing in Bermuda. T. Bjornson is in Montreal, training to become a T.C.A. stewardess. E. Sutherland, 4th south, Miss Scott, pediatrics, and Miss Rutherford, central dressing room, are leaving for Britain. S. Cox and Mrs. Tyerman have left for Cuba while G. Larsen, central dressing room, is on her way to Egypt.

VICTORIA

The formation of the Nursing Division of the Disaster Committee, under the auspices of the Red Cross, was undertaken on the advice of Dr. Gayton, public health officer, who requested the Victoria Chapter to undertake this organization which would be available in event of disaster.

Mrs. S. Cave, who is representative for Red Cross nursing affairs in the city, was appointed chairman of the core committee and Mrs. J. H. Russell, chapter president at that time, was appointed alternate chairman.

The permanent core committee consists of the chairmen as noted above, Mrs. R. Brown, the present president of the chapter; M. E. Dickson, superintendent, Nurses' Directory, Victoria; J. E. Jamieson, first vice-president of the chapter; M. Straith and Mrs. R. T. Davis.

A meeting of representatives from each of the nursing groups—public health, V.O.N., office nurses, institutional and private nurses—was called and Dr. Laura Holland, representing social workers, as well as a representative from St. John Ambulance were invited to the initial meeting of the committee. Alumnae associations are not included as such, as members are in the various categories already mentioned.

Registration forms were compiled and registered nurses, nurses' aides, undergraduates, V.A.D.'s, practical nurses, orderlies, x-ray and laboratory technicians were requested to register. The request for registration was made during the previous week by means of the press and radio, nursing organizations, and institutions. Places of registration and times were included in the notice and it was necessary to have members of the committee present at registration centres to give direction in the filling out of the forms correctly. Directives for members assisting with registration forms proved helpful to ensure registrants being given similar instruction.

The city of Victoria was divided into zones, using maps showing streets, and the committee, using the registration forms, placed the registrants in zones according to place of residence.

Institutional nurses were included in registration and zoning because of frequent changes of type of employment. The core committee called a meeting in each zone with a captain and alternate captain (wherever possible registered nurses were appointed to these offices). At the same meeting, a committee was appointed for the purpose of organizing teams in each zone. It was felt that sharing the responsibility created more interest for the registrants in each zone. Classification of members of teams was made according to the requirements suggested by Dr. Gayton.

Quadruple lists for each zone are compiled in alphabetical order. Names, addresses, and phone numbers are included. These lists are filed in loose-leaf folders with a map of the zone placed in the front cover of the folder and an envelope in the back cover for notices, etc. One folder is issued to each zone captain and alternate captain, one to the Nurses' Registry office, and one is kept in the Red Cross office.

Early in May, the core committee met with Dr. Gayton and Mr. Hatcher, newly appointed coordinator of Civil Defence for Greater Victoria, and it was decided that the committee would work with the Civil Defence Organization.

The following is a summary of the activities of Victoria Chapter for the past months:

They Look So Fine—and Feel DIVINE!

The CLINIC SHOE
REG. U.S. PAT. OFF. & CANADA
for Young Women in White

There's heavenly comfort in good-looking, foot-flattering CLINIC SHOES. They're supple, flexible, perfect-fitting; with ample support to help reduce fatigue. "Nothing could be finer" for young women who are constantly on their feet . . . Genuine Goodyear Welts.

$13.45, $14.45, $15.45
(according to styles and leathers)

FOR YOU!
A PAIR OF WHITE SHOE LACES
Send us your name and address and receive a complimentary pair of shoe laces and illustrated leaflet of 23 styles.
Dept. 4
THE CLINIC SHOEMAKERS,
1221 LOCUST ST., ST. LOUIS 3, MO.

UNIVERSITY OF MANITOBA

POST-GRADUATE COURSES FOR NURSES

The following one-year certificate courses are offered:

1. **Public Health Nursing.**
2. **Teaching and Supervision in Schools of Nursing.**

For further information apply to:

Director
School of Nursing Education
University of Manitoba
Winnipeg, Man.

WINNIPEG GENERAL HOSPITAL

Offers to qualified Registered Graduate Nurses the following:

- A six-month **Clinical Course in Obstetrics,** including lectures, demonstrations, nursing classes, and field trips. Four months will be given in basic Obstetric Nursing and two months of supervisory practice in Supervision, Ward Administration, and Clinical Teaching. Maintenance and a reasonable stipend after the first month.
- Course begins ***Sept. 4, 1951,*** and ***Jan. 2, 1952.*** Enrolment limited to a maximum of eight students.

For further information write to:

Supt. of Nurses, General Hospital, Winnipeg, Man.

At the Royal Jubilee Hospital, Dr. John E. Harvey delivered an address on "Brain Surgery." The talk was followed by an excellent demonstration on post-operative positions given by B. Davis and J. MacGregor. Dr. Digby Lee, anesthesiologist from Vancouver, spoke to the nurses on "Modern Trends in Anesthesia" in February, followed by a demonstration in recovery room procedures, conducted by Mrs. T. Bavin of R. J. H. Ferne Trout, itinerant instructor, R.N.A.B.C., gave a talk on "Newer Drugs." Dr. J. D. Stenstrom gave an address on "Intrathoracic Surgery." Sr. M. Winnifred, of St. Joseph's Hospital, demonstrated the suction apparatus used by Dr. Stenstrom. The chapter members were addressed by M. Bloomberg, head physiotherapist at St. Joseph's, on "Body Mechanics." Miss Bloomberg also gave a short demonstration. Gertrude Hall, general secretary, C.N.A., spoke on "Nursing in the Future" at R.J.H. "Nursing in Atomic Warfare" was the topic chosen by Margaret Campbell in June.

MANITOBA

BRANDON

Sixteen graduates of the General Hospital were present as guests of honor at the annual dinner and dance given by the Association of Graduate Nurses. M. Jackson, superintendent of nurses, E. MacKenzie, and Mrs. G. Hotson participated in the various toasts. Tribute was paid to the late Mrs. J. Esslemont who had been a devoted member and inspiration to all. Musical entertainment was provided by M. Wilson, B.G.H. student nurse, P. Donohue, G. Roper, Mental Hospital student nurse, and E. Friesen. The guest speaker was Rev. A. H. Cummings, who pointed out the similarities between the ministry and the nursing profession. He was thanked by Mrs. S. Perdue.

A business meeting followed, with Mrs. E. Griffin in the chair. L. Arnott reported on the M.A.R.N. 37th annual convention. L. Booth gave the secretary's report and J. Markey that of the treasurer.

The Nominating Committee presented the following slate of officers: President, Mrs. G. Hotson; vice-presidents, D. Lewis and A. Colter; secretary, L. Arnott; treasurer, Mrs. R. Catley. Committee conveners: Scholarship, Mrs. L. Moir; social, A. Chisholm; Cancer Tag Day, Mrs. D. Johnson; visiting, Mrs. L. Mathie; Cook Book Fund, A. Bennett. Representatives to: Press, L. Booth; *The Canadian Nurse,* B. Daniels. Registrar, M. Jackson.

Mrs. M. Ferguson gave a vote of thanks to the retiring committee and also to Mrs. A. Wiley and her committee who were in charge of the dinner and dance arrangements.

At the graduation exercises of the General Hospital, L. Beresford, vice-chairman of the hospital Board of Directors, presented diplomas to 17 nurses, while Miss Jackson awarded them with their pins. Scholarships and prizes were won by the following: J. Kenean, L. Millions, C. Scott, W. Elliott, E. MacKenzie, K. Perepeletza, K. Whillier,

H. Kalakailo, S. Mori, G. Sturko, F. Cady, H. Chapple, and M. Barrett.

The address to the graduates was delivered by the Rt. Rev. I. A. Norris, Bishop of Brandon, his thoughts revolving around the subject "Learning the Lessons of Life."

Other graduation highlights included a dinner at the home of Mrs. Lane, with Mrs. Walker as co-hostess; teas at the homes of Mmes Elliott and Hagan; dance given by senior students; "Mother and Daughter" tea.

Some 45 to 50 students and graduates from the Mental and General Hospitals attended the special church service in May, conducted by Rev. H. G. Rees at First United Church.

NEW BRUNSWICK

MONCTON

Fifteen members were present at a recent meeting of the Nurses' Hospital Aid when the president, Mrs. J. Pettet, was in the chair. A letter from the J. F. Hartz Co. Ltd. was read regarding the modern humidity and oxygen tent which the Aid is to finance for the pediatric ward of Moncton Hospital. Miss Breau, superintendent of nurses, was instructed to purchase this essential equipment if so desired. Mrs. L. Munn reported on the "Rolling Dollar" project. Mrs. W. C. McKee was named as an alternate to attend the Maritime Hospital Convention if Mrs. Pettet cannot be present. A new member—Mrs. N. P. Kent—was welcomed to the meeting.

SAINT JOHN

F. Saunders was in the chair at a regular meeting of Saint John Chapter when an illustrated lecture was given by Dr. C. R. Trask on "Atomic Energy."

Lancaster Nurses' Association

At a meeting of the association, plans were completed for a coffee party to be held in honor of members of the staff who are resigning. Evelyn Hunter was presented with a suitable gift on her departure from the staff. E. Abbott presided.

ST. STEPHEN

At a meeting of St. Stephen Chapter each member brought a new magazine for the use of patients in hospital. Four films were shown, D. Parsons and C. Boyd serving as projectionists. At a later meeting, held at Charlotte County Hospital, Mrs. C. Parks presided in the absence of Miss Dunbar. The secretary reported that 45 nurses attended worship at Presbyterian Church on May 6. Registered nurses, including members of the hospital staff, and students were represented. Mrs. Beek reported $132.28 as the proceeds from the rummage sale. It was stated by Miss Boyd that, since January, the Ways and Means Committee had turned in $334 to the treasurer. The members learned that the Nurses' Registry would be included in the yellow pages of the new telephone directory. A committee was appointed to purchase gifts

THE BRITISH COLUMBIA CIVIL SERVICE ***requires—***

PUBLIC HEALTH NURSES, GRADE I—(for the Department of Health & Welfare, Province of British Columbia).

Salary: $201.50 rising to $228 per mo. (including current Cost of Living Bonus).

Qualifications: Candidates must be eligible for registration in British Columbia and have completed a University degree or certificate course in Public Health Nursing. (Successful candidates may be required to serve in any part of the Province; cars are provided.)

Further information may be obtained from the *Director, Public Health Nursing, Dept. of Health & Welfare, Parliament Bldgs., Victoria.*

Candidates must be British Subjects, under 40 years of age, except in the case of ex-service women who are given preference, unmarried, or self-supporting. Application forms obtainable from all *Government Agencies, the Civil Service Commission, Weiler Bldg., Victoria,* or *636 Burrard St., Vancouver,* to be completed and returned to the **Chairman, Victoria.**

DALHOUSIE UNIVERSITY

Courses for Graduate Nurses

Term 1951-1952

The School of Nursing offers one-year Diploma Courses in the following fields:

1. ***Public Health Nursing.***
2. ***Teaching and Supervision in Schools of Nursing.***

For further information write to:

The Director
School of Nursing
Dalhousie University
Halifax, N.S.

ROYAL VICTORIA HOSPITAL
School of Nursing, Montreal

COURSES FOR GRADUATE NURSES

1. A four-month clinical course in **Obstetrical Nursing.**

2. A two-month clinical course in **Gynecological Nursing.**

Salary—After second month at General Staff rates.

For information apply to:

Director of Nursing
Royal Victoria Hospital
Montreal 2, Que.

McGill University
School for Graduate Nurses
1266 Pine Ave. W., Montreal 25

—Bachelor of Nursing Courses—

Two-year courses leading to the degree, Bachelor of Nursing. Opportunity is provided for specialization in field of choice, registering in any of the major fields indicated by asterisk.

—One-Year Certificate Courses—

* Teaching in Schools of Nursing.
* Administration in Schools of Nursing.
* Public Health Nursing.
* Administration and Supervision in Public Health Nursing.
Supervision in Psychiatric Nursing.
Supervision in Obstetrical Nursing.
Supervision in Paediatric Nursing.

for the graduating class of C.C.H. and further plans were made for the N.B.A.R.N. annual meeting to be held in St. Stephen, September 26-27. The guest speaker was Mr. R. R. McNeill, director of personnel, Canadian Cottons, Milltown. His subject was "Personnel."

NOVA SCOTIA

ANTIGONISH

A home nursing course is being conducted under the general convenership of Louise MacDonald, former matron of Camp Hill Hospital, Halifax. Mrs. J. J. Carroll assisted in the organization of this course. Several nurses are cooperating, including V. MacKinnon, M. MacGillivray, Mmes P. MacNeil, D. D. MacDonald, Douglas MacDonald, and H. Saulnier. Mrs. H. R. Matthews is conducting a similar course in Goldboro, Guys. Co.

Graduation exercises for the 34 members of the 1951 class of St. Martha's Hospital School of Nursing were held recently when mass was celebrated earlier by the Most Rev. J. R. MacDonald, D.D., at the Motherhouse of the Sisters of St. Martha. Rev. Father Wm. Gallivan, president, Board of Directors, was chairman. The Most Rev. MacDonald presented the diplomas and awards. Professor Allan MacEachern, of the Sociology Department of St. Francis Xavier University, addressed the graduates. Mary E. MacDonald of Allston, Mass., contributed vocal selections. At the conclusion of the ceremonies, the alumnae were hostesses to the graduates and their friends at a tea.

The following day the alumnae association honored the graduates at a banquet when the president, Mrs. Hugh MacPherson, LL.B., received the new class into the association. The guest speaker was Mr. George Boyle of the Extension Department of St. Francis Xavier University. Graduation Ball concluded the events.

Mrs. MacPherson, of the class of 1941, was admitted to the bar, together with her husband, in May, 1950. They opened their office in Antigonish September of that year. Mrs. MacPherson, as well as being president of her alumnae, is also president of the local Red Cross Society.

PICTOU COUNTY

This county, although small, has many industries and sporting centres. Within the towns comprising this county, many have received their preliminary education and have later become people of note. In each of the five towns—Pictou, Westville, Stellarton, New Glasgow, and Trenton—may be found public schools, including the Pictou Academy, and places of worship for all creeds. Within the county are two hospitals—Sutherland Memorial and Aberdeen. The former is located in Pictou, overlooking the harbor. Operated on a small scale, it serves the town and surrounding locality.

The 170-bed Aberdeen Hospital in New Glasgow is a large, brick institution, situated on a hill overlooking the town and the East River. The superintendent has under her supervision 18 graduate staff nurses and 52 student nurses who are enrolled by the hospital twice a year with graduation exercises in June. Plans are in the offing for the erection of a new hospital in the county.

There are 61 graduates on the county register and last year 1,110 calls were received for private duty nurses.

Coal mines, steel plants, mattress factory, cutlery works, and ship-building all may be found in the county. The scenic beauties may be viewed from the Green Hill Look-Off which is a high tower overlooking the entire county.

ONTARIO

DISTRICTS 2 AND 3

BRANTFORD

The Spring meeting of the districts was held in May when the Brantford General Hospital Alumnae Association were hostesses. Approximately 122 members registered, Mrs. J. Sanders presiding. The committee reports showed a very busy year. Highlights from the R.N.A.O. annual convention were given by the district representative, M. Dunsmore. Mrs. Sanders reported on the directors' meeting and the progress made regarding the Nurses' Registration Act.

Main discussion centred on the division of Districts 2 and 3. District 2 would include the counties of Brant, Oxford, Perth, Huron, and Norfolk. District 3 would take in Bruce, Grey, Dufferin, Wellington, and Waterloo.

The guest speaker at the dinner was Mrs. M. D. L. McLellan who spoke on her trip to Labrador. She was introduced by Mrs. A. Grierson. The convener for the meeting was Mrs. L. Hurley.

The next meeting is planned for October at the Kitchener-Waterloo Hospital.

General Hospital

The annual Nurses' Memorial Service was held on May 6 in Colborne St. United Church under the leadership of the alumnae association. A choir of 44 student nurses participated, H. Riddolls contributing a solo. M. Terryberry, alumnae president, and O. Plumstead, in charge of arrangements, also took part in the service. Rev. B. L. Oates spoke on "Areas of Choice." M. McIntosh, student nurse, was pianist. The ushers included D. Allin, M. Edward, V. Sam, S. Matthews, M. Gillin, and Mrs. A. Hodgins.

At a recent meeting of the alumnae, Glenna Beckham, of the class of 1944, described her work in outpost hospitals at Fort Norman and Fort Franklin, N.W.T. A letter was read from Mrs. M. (Cody) Applewhite, nurse in charge, Cape Dorset, Baffin Island.

DISTRICT 4

Hamilton General Hospital

A recent meeting of the alumnae association took the form of a bridge and canasta

THE ART AND SCIENCE OF NURSING

By Ella L. Rothweiler and Jean Martin White. New edition of a leading textbook, widely used in schools of nursing. The material has been completely revised and brought up to date. Several new chapters have been added, with more nursing procedures and more illustrations. 180 illustrations, 895 pages, fourth edition, 1950. $5.00.

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Superintendent of Nurses, Toronto Hospital, Weston, Ontario.

party when 60 tables were taken by the nurses and their friends. Numerous prizes were drawn for. Refreshments were prepared and served by the married members of the association. Proceeds will go towards the publication of "The History of the School of Nursing" and the Diamond Jubilee celebration.

DISTRICT 5

BARRIE

Eighty-seven members of the district, at the invitation of Chapter 2, met in Barrie for the Spring General Meeting. The committee reports indicated activity for the district and its chapters. The program convener announced that there was a good attendance at the annual Memorial Church Services in Toronto on May 6, held at Timothy Eaton Memorial Church and St. Michael's Cathedral. The Bursary Committee is continuing its outstanding work.

The district will form a committee to take care of the request for linen from the Central Council of District Nursing, London, Eng. A recommendation from Chapter 2, requesting the formation of a new district to include Chapter 2 (Simcoe County) and the lower part of District 9, and to be known as District 11, was approved. The report on the newly formed Inter Club Council for Women in Public Affairs was well received and a vote carried that the district support this project in principle.

The guest speaker was Mrs. M. Hamilton, mayor of Barrie, whose address was entitled "A Woman of Today." After commenting on the accomplishments of outstanding women in history, she gave some pointers for the modern woman entering public life in any field. Believing in femininity, Mrs. Hamilton said, "Only those who make the breaks get the breaks."

Toronto Western Hospital

The Cavell Choristers, a talented and zestful group of student nurses at the hospital, singing well-loved songs both old and new, contributed in generous measure to the success of the May meeting of the alumnae association. The Choristers, organized in March, 1950, whose practice and rehearsal time is squeezed from their own scant leisure, reflect considerable credit on their singing instructor, Mr. A. G. Ferchat, A.T.C.M., performing with so much delicacy and precision.

The alumnae president announced the award by the association of two scholarships for post-graduate study in nursing education —the Beatrice L. Ellis Scholarship won by Anne Gribben (1945) and the Georgie L. Rowan Memorial Scholarship by Joan A. Cotie (1950). Following the meeting, the members were escorted through the almost-completed Education Building.

The class of 1951 were guests at a dance given in their honor by the alumnae and the Women's Board.

DISTRICT 6

COBOURG

The semi-annual meeting of the district was held in May after a turkey dinner planned by Chapter B. Ninety-nine members were present. Reports from the three chapters and special committees were read. Mrs. J. Patterson gave a brief account of the general session of the R.N.A.O. annual convention and A. L. Thomson commented on the board meetings held at that time.

Mrs. M. Pringle of Peterborough was elected third vice-chairman of the district to replace E. Murphy who had resigned. Miss Sheppard of Trenton will represent *The Canadian Nurse*. Miss Droppo of Trenton was named as convener of the Nominating Committee, M. Pickens of Peterborough to be her assistant.

The guest speaker, introduced by L. Steele, was Dr. R. P. Robertson, a dentist, who spoke about his work among the Eskimos and Indians in the Arctic. His address was accompanied by colored slides. Dr. Robertson was thanked by Miss Lehigh.

The district annual meeting will be held in Peterborough in October and will be a combination symposium, meeting, and dinner.

DISTRICT 8

OTTAWA

Lady Stanley Institute Alumnae

The following officers were elected to serve during the coming months by the Lady Stanley Institute Alumnae Association: Honorary president, Mrs. W. S. Lyman; honorary vice-presidents, M. Stewart, E. Young; president, Mrs. L. R. Gisborne; vice-president, Mrs. J. A. Steele; secretary, M. Slinn; treasurer, M. Scott; directors, C. Pridmore, Mmes M. E. Jones, W. A. Oliver, W. E. Caven; flower convener, D. Booth; representatives to: Local Council of Women, Mrs. C. A. Port; Community Nurses' Registry, M. Scott; press, M. Ralph; *The Canadian Nurse*, E. Johnston.

St. Luke's General Hospital Alumnae

A very successful bridge was recently sponsored by St. Luke's General Hospital Alumnae Association when the president, Diana Brown, and past president, I. Allen, received the guests. The proceeds will be used in aid of charitable organizations.

DISTRICT 10

FORT WILLIAM

Mrs. D. R. Easton, the chairman, presided at a meeting of the district when Mr. Priestman of Toronto addressed the members on "Group Insurance for Nurses." This plan is being sponsored by the R.N.A.O. A musical film was shown by H. Scriminger and M. Stitt. At the close of the meeting, tea was served by members of the McKellar Hospital nursing staff.

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QUEBEC

MONTREAL

The Memorial and Rededication Service was held in Erskine and American United Church on May 6 and was well attended by nurses in uniform from the hospitals of the city.

Royal Victoria Hospital

The 91 members of the graduating class were guests of honor of the alumnae association at a dinner when Dr. W. J. McNally, otolaryngologist-in-chief, was the guest speaker. W. MacLean, assistant director of nursing, proposed the toast to the new graduates, which was responded to by M. Fleming. H. Lamont, director of nursing, announced the winners of the alumnae awards: For highest aggregate marks in examinations—Mabel F. Hersey Prize—Janet Baird (Miss Baird also won the *Canadian Nurse* Award—for greatest growth in professional development during her period of training); Nellie Goodhue Prize—Jean Atkinson; for bedside nursing—Alexina Dussault Prize—Beatrice Evans. Janet MacKay, the president, was in the chair. Three undergraduates contributed to the musical part of the program.

At the graduation exercises, Professor Hughes of the Department of Education, McGill University, addressed the graduates and their friends. The dance and Parent and Daughter Tea were also enjoyed by the 1951 class.

At the annual meeting of the alumnae reports were received from the conveners and a new board of directors installed. Miss MacKay will continue to serve as president. Several entertainments have been held in aid of the Building Fund.

Recent visitors to the hospital include: Mrs. C. (Reeves) Leslie, South Africa; Mrs. (Kuhring) Hallett, Oakville, Ont.; Mrs. A. (Lawson) Cheney, Vancouver; Mrs. M. (Lawson) Wright, Trail, B.C.

Verdun Protestant Hospital

In May at the Verdun Protestant Hospital an award was presented from the Canadian Mental Health Association to Mr. F. Warder, male attendant, in recognition of 29 years of service in the hospital. The premiere of the fifth in the Mental Mechanism Series of movies, produced by the National Film Board, also took place. This film, entitled "Breakdown," was prepared in Essondale, B.C., under the direction of Mr. Roy Anderson and with the advice of Dr. G. E. Reed, medical superintendent, and Dr. Heinz Lehmann, clinical director, both of V.P.H.

QUEBEC CITY

Jeffery Hale's Hospital

At a meeting of the alumnae association, Mrs. J. Pugh and Miss MacDonald were elected to attend the annual convention of the A.N.P.Q. in Montreal. At a recent bridge a pair of blankets and a camera were raffled and won by Mrs. Kingswell and Miss Whealan.

SHERBROOKE

The Memorial and Rededication Service was held in May at St. Andrew's Church when District 3, A.N.P.Q., placed flowers on the Communion Table in memory of the late E. Frances Upton. Many student and graduate nurses attended in uniform as well as several inactive nurses.

At the annual graduation exercises of Sherbrooke Hospital School of Nursing, J. G. Armitage, Board of Governors president, assisted V. Graham, director of nursing, in presenting the diplomas and pins. The guest speaker was Margaret Street, secretary-registrar, A.N.P.Q. Dr. G. B. Loomis, representing the Medical Board, also spoke to the graduates and wished them success. The invocation was given by Rev. W. R. Adam. Prizes were presented to A. Cook, M. Aldrich, V. Davies, E. Bennett, and L. Coates.

The following night the class of 1951 was entertained at dinner by the alumnae association when about 70 were present. Grace was said by Miss Graham. Mrs. G. Vaudry, alumnae president, J. Dow, and J. Peasley participated in the various toasts.

The graduates were also entertained by the Governors of the hospital at the Norton Residence when dancing was enjoyed.

The alumnae was recently taken on a tour of the new hospital and, contrary to a previous decision, it was decided to furnish a unit in the children's ward rather than the graduates' room. A drawing and a rummage sale netted substantial amounts towards this project.

SASKATCHEWAN

YORKTON

Mrs. S. Dodds presided at the annual banquet given by the General Hospital Alumnae Association in honor of the 20 members of the 1951 graduating class. The guest speaker was Hazel Keeler, director of the University of Saskatchewan School of Nursing, and adviser to schools of nursing in the province. Miss Keeler, in her address, traced the history of the nursing profession from the days of Florence Nightingale up to the present. The speaker was thanked by Mrs. H. Ellis.

Alumnae members met at the home of Mrs. J. Parker in honor of Mrs. C. Heinrich who will reside in Bredenbury. A souvenir coffee spoon, with a nurse's crest, was presented to Mrs. Heinrich by Mrs. W. Westbury, on behalf of those present. Court whist was played, Mmes T. Stewart and S. N. Wynn being the winners.

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Clinical Instructor (qualified) & **Registered Nurses for General Duty.** Liberal salaries. 8-hr. day, 6-day wk. Apply for further information Supt. of Nurses, St. Joseph's Hospital, Guelph, Ont.

Public Health Nurse for Brooks Health District. Car & 2-room suite provided. Apply G. E. Smith, Sec., Brooks, Alta.

Clinical Supervisor for Jeffery Hale's Hospital, Quebec City, Que., to be responsible for clinical teaching of students. Attractive salary & residence. Apply, stating qualifications, to Director of Nurses.

Head Nurse for Tuberculosis Sanatorium, Foothills. Salary: $278 less $37.50 maintenance. Apply Wish-I-Ah Sanatorium, Auberry, California.

General Duty Nurses for Operating Room, Pediatrics, General, Surgical & Medical Nursing for summer relief or permanent positions. For information & personnel policies apply Director of Nursing, Victoria Hospital, London, Ont.

Registered Nurses for General Duty in Tuberculosis Sanatorium, 7½ miles from Prince Rupert, B.C. Salary: $203 with yearly increases to $231 per mo., less $30 per mo. for room, board & laundry. Regular Civil Service sick leave & holidays. Transportation refunded on arrival on promise of 1 yr. service. Apply, giving full qualifications & experience in 1st letter by airmail, Dr. J. D. Galbraith, Medical Supt., Miller Bay Indian Hospital, Prince Rupert, B.C.

Clinical Instructors in Surgical & Obstetrical Nursing. Salary: $250-270 with merit increases to $290. **Communicable Disease Head Nurse** for 29-bed dept. Salary: $245-255. **General Staff Nurses** for summer relief or permanent duty on Medical, Surgical, Obstetrical & Communicable Disease floors & Newborn Nursery. Salary: $220-240 with differential of $15 per mo. for evening & night duty. 3 wks. vacation. 6 legal holidays or equivalent. General Hospital on Lake Michigan, 14 miles from Chicago. Apply Director of Nursing, Evanston Hospital, Evanston, Illinois.

Registered Nurses for Sunnybrook & Westminster Hospitals, Toronto & London, Ont. Salary: $2,160-2,772 per annum. Information & application forms available at Post Offices. The latter should be filed with the Civil Service Commission of Canada, 1207 Bay St., Toronto 5, Ont., as soon as possible.

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Directrice Nationale, Services du Nursing,
La Société Canadienne de la Croix-Rouge,
95 rue Wellesley, Toronto 5, Ontario, Canada

Matron within next few months for 25-bed hospital in Interior of British Columbia. Starting salary: $175 per mo. plus full maintenance. 8-hr. day. 10 statutory holidays. 1 mo. ann. vacation with pay after 1 yr. service. Sick leave, 1½ days per mo. Hospital on Kootenay Lake, one of the most beautiful parts of B.C. **General Duty Nurses.** Starting salary: $150 plus full maintenance. Train fare refunded after 1 yr. satisfactory service. Apply, giving full particulars, Sec., Victorian Hospital, Kaslo, B.C.

Nursing Instructor to initiate student affiliation & staff education program in 600-bed Tuberculosis Hospital. Apply Director of Nursing, Beck Memorial Sanatorium, London, Ont.

Instructor of Nurses for 55-bed hospital. Apply, stating age, experience & salary expected, F. L. Weldon, Sec.-Treas., Ross Memorial Hospital, Lindsay, Ont.

Registered Nurse with Public Health Training to take charge of health program in schools under Richmond-Drummond-Arthabaska Protestant Central School Board. For Sept. 1. Full-time work. Holidays with pay. Salary & travelling expenses. Apply, giving full particulars of training, experience & references, C. W. Dickson, Supervisor of Schools, Box 207, Richmond, Que.

Public Health Nurses for Northumberland-Durham Health Unit following the marriage of 5 staff nurses during past yr. Generalized program in towns & rural areas provides experience in all phases of public health. Salary schedule: $2,200-2,900. Car provided or car allowance. Inquiries to Dr. C. W. MacCharles, Director, Northumberland-Durham Health Unit, Cobourg, Ont.

General Duty Nurses for Children's Hospital, 250 W. 59th Ave., Vancouver, B.C. 44-hr. wk. Credit given for past experience. 28 days vacation; also statutory holidays. B.C. registration requested. Apply Supt. of Nurses.

General Duty Nurse—medical, surgical, pediatrics, contagious, maternity, tuberculosis. Beginning salary: $255 with $10 differential for all except medical & surgical. Same differential for evening & night shifts. 680-bed hospital with School of Nursing. 40-hr. wk. 11 paid holidays. 3 wks. vacation. Laundry. Cumulative sick leave. Apply Director of Nursing Service, General Hospital, Fresno, California.

Operating Room & General Duty Nurses for modern 100-bed hospital. Starting salary: $145 per mo. plus board & laundry. Credit for past experience. Annual increments. 2 wks. sick leave after 1 yr. 3 wks. annual vacation. Apply Sr. Superior, St. Mary's Hospital, Camrose, Alta.

Registered, Graduate & Undergraduate Nurses for small hospital in attractive northern Ontario town. Salary: $140 per mo. plus full maintenance to R.N.'s. Others according to qualifications. Apply Supt., Lady Minto Hospital, Cochrane, Ont.

Registered Nurses, General Staff, for new hospital opening July. Starting gross salary: $175 per mo. 46-hr. wk. 2 increases in salary. $10 differential for afternoon duty. 28 days vacation after 1 yr. For further details apply Director of Nurses, General Hospital, Guelph, Ont.

Science Instructor & Nursing Arts Instructor by Sept. 10 for School of Nursing of 40 students. Excellent salaries offered. Apply, stating qualifications, Supt. of Nurses, St. Mary's Hospital, Timmins, Ont.

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Registered Nurses for General Staff Duty on Rotation Service. Apply Director, Shriners' Hospital for Crippled Children, 1529 Cedar Ave., Montreal 25, Que.

General Duty Nurses for 400-bed hospital. New Wing just opened. 8-hr. day, 44-hr. wk. 10 statutory holidays. B.C. registration required. Salary: $175 basic. Credit for past experience. Annual increments. Vacation: 28 days after 1 yr. Sick leave: 1½ days per mo. cumulative. Apply Director of Nursing, Royal Columbian Hospital, New Westminster, B.C.

Science Instructor (experienced, B.Sc. required) & **Asst. Nursing Arts Instructor** (cert. in Teaching & Supervision required). Beginning salaries dependent on experience & qualifications. Both positions vacant Aug. **Operating Room Nurses** (experienced). Beginning salary dependent on post-graduate preparation & previous O.R. experience. **General Duty Nurses.** Basic beginning salary: $147.50 per mo. All personnel receive, in addition to salary, 2 meals & laundry. 48-hr. wk., straight shift. Afternoon & night shift differential. Sick leave. Annual increment of $60 per yr. over period of 4 yrs. Statutory holidays. 14 days vacation 1st yr. & 1 mo. hereafter. Apply Supt. of Nurses, General Hospital, Winnipeg, Man.

Operating Room Nurses (experienced). Also **General Duty Nurses.** Apply Director, Nursing Services, Toronto Hospital for Treatment of Tuberculosis, Weston, Ont.

Educational Director; Evening Supervisor; Head Nurse for Medical-Surgical Division; Clinical Instructor in Obstetrics. Salary range for last 3 positions: $190-205 per mo. Apply A. D. Potts, Director of Nursing, General Hospital, Belleville, Ont.

Nursing Arts Instructor for General Hospital, Hamilton, Ont. Nurse experienced in bedside nursing & ward administration & with post-graduate course in Teaching & Supervision required. Initial gross salary bi-weekly: $99 plus Cost of Living Bonus of approx. $3.00. 44-hr. wk. For other perquisites—vacation, illness, pension, etc.—& further information apply Supt. of Nurses.

Graduate Floor Duty Nurses for Mt. Hamilton Maternity Hospital, Hamilton, Ont. 44-hr. wk. Statutory holidays. Initial gross salary bi-weekly: $79 plus Cost of Living Bonus. For other perquisites & further information write Supt.

Graduate Floor Duty Nurses for General Hospital, Hamilton, Ont. Gross initial bi-weekly salary: $79 plus Cost of Living Bonus of approx. $3.00. 44-hr. wk. For other perquisites & further information write C. E. Brewster, Supt. of Nurses.

Alberta Civil Service, Tuberculosis Division, Dept. of Health, requires: ***Registered General Duty Nurses***; also ***Tuberculosis Trained Nurses*** by Sept. 1 for opening of new 300-bed Aberhart Memorial Sanatorium, located on University Campus, City of Edmonton. All major services. Salary: General Duty, $150 per mo. plus Cost of Living Bonus, at present $32.50. Annual increment, $60 over 4-yr. period. Charge Nurses, $160 per mo. Cost of Living Bonus & annual increments as above. 8½-hr. day, 5½-day wk. Rotating shifts for General Duty Nurses. 33-day annual vacation. Sick leave determined by length of service. Pension Plan. Nurses' Residence (bed-sitting rooms) ready for occupancy Nov. 1. Deduction for those living in, $30 per mo. for room, board, laundry. Information & application forms available from Supt. of Nurses, Central Alberta Sanatorium, Calgary, Alta.

Public Health Nurses for Peel County Health Unit for generalized program. Unit is near Toronto. Salary range: $2,200-2,600 per yr. Liberal car allowance, holiday & sick leave benefits. For full information write Dr. D. G. H. MacDonald, Court House, Brampton, Ont.

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Registered Nurses for General Staff at Ontario Hospitals in Brockville, Hamilton, London, New Toronto, Orillia, St. Thomas, Toronto, Whitby, Woodstock. Initial salary: $1,840 per annum plus $240 Cost of Living Bonus, less perquisites ($26.50 for room, board, laundry). Annual increment, accumulative sick leave, superannuation, 3 wks. vacation, statutory holidays & special holidays with pay. 8-hr. day, 44-hr. wk. Apply Supt. of Nurses at above hospitals.

Public Health Nurses immediately for Greater Montreal Branch, Victorian Order of Nurses. Interesting program of nursing care & health counselling in homes. Stimulating staff education program. 5-day wk. 4 wks. vacation. Initial salary: $2,160. Apply District Supt., V.O.N. 1246 Bishop St., Montreal 25, Que.

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Registered Nurses for General Staff in 21-bed hospital. Salary: $155 per mo. Room, board, uniform laundry provided. Rotating shifts. 48-hr. wk. Blue Cross Plan. 3 wks. holiday after 1 yr. service. Apply Supt. of Nurses, General Hospital, Espanola, Ont.

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Instructor of Nursing & Clinical Supervisor. Apply Director of Nursing, Victoria Public Hospital, Fredericton, N.B.

British Columbia Civil Service requires: ***Registered Nurses for General Staff Duty for the Division of Tuberculosis Control***—*Vancouver Unit:* 225-bed T.B. Hospital, located at 2647 Willow St., Vancouver. All major services & student affiliation course. Registration in B.C. required. Gross salary: $182 per mo. Annual increments of $60 (over 5-yr. period). No residence accommodation. *Tranquille Unit:* 350-bed T.B. Hospital, located 12 miles from Kamloops in southern interior. All major services except student affiliation. Gross salary: $188.50 per mo. Annual increments of $60 (over 5-yr. period). New modern residence; attractive bed-sitting rooms. Recreational facilities. Maintenance deduction: Room $5.00; laundry $2.50. Excellent food at 20 cts. per meal. ***Conditions—Both Units*:** 8-hr. day, 5½-day wk. rotating shifts. 4 wks. annual vacation with pay plus 11 statutory holidays. Sick leave, 20 days per yr. (14 cumulative). Promotional opportunities. Superannuation. Write for information & applications to Supt. of Nurses in respective Units or to Director of Nursing, Division of T.B. Control, 2647 Willow St., Vancouver, B.C.

Dietitian for 100-bed hospital. Salary depends on experience & qualifications. For particulars apply Supt., Soldiers' Memorial Hospital, Campbellton, N.B.

Graduate Nurses (male & female) for 45-bed hospital. Salary: $120 per mo. plus full maintenance. 8-hr. day, 6-day wk. 3 wks. vacation with pay after yr. of service. 7 statutory holidays. Sick time allowance. Apply Supt., County of Bruce General Hospital, Walkerton, Ont.

Nursing Arts Instructor, Asst. Operating Supervisor, Night Supervisor, General Duty Nurses for 200-bed General Hospital. Salaries: $195, 195, 205, & 175 plus Cost of Living Bonuses, respectively. 8-hr. day, 88-hr. fortnight. Statutory holidays. Sick time. 4 wks. annual vacation. Apply Supt. of Nurses, Royal Inland Hospital, Kamloops, B.C.

General Duty Nurses (**2**) for 60-bed hospital. 48-hr. wk. Salary: $125 per mo. with 2 annual increments of $5.00. Full maintenance. 4 wks. vacation at end of 1 yr. service. Apply Supt., General Hospital, Goderich, Ont.

Vancouver General Hospital requires: **General Staff Nurses**—Salary: $185-215 plus afternoon & night shift differential. Perquisites: 44-hr. wk.; 11 statutory holidays; 28 days vacation; 1½ days per mo. cumulative sick leave; Pension Plan (if under 35). Apply Director of Nursing, General Hospital, Vancouver, B.C.

General Duty Nurses for 350-bed Tuberculosis Hospital in centre of Laurentian summer & winter resort area, 2 hrs. from Montreal. Starting salary: $125 per mo. plus full maintenance. Attractive working hrs. with 1½ days off weekly & 1 week-end each mo. 1 mo. annual vacation. 14 days sick leave. Apply Director of Nursing, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, Que.

Graduate Nurses for modern 100-bed hospital, 60 miles from Vancouver on Trans-Canada highway. Basic salary: $175 plus present C.O.L. adjustment $5 increase. 4 annual increments, $10, $5, $5, $5. Board, residence, laundry charges, $35 per mo. 44-hr. wk. 10 statutory holidays: 28 days annual vacation. 1½ days sick leave per mo. accumulative to 36 days. Apply Supt. of Nurses, Chilliwack Hospital, Chilliwack, B.C.

General Duty Nurses. Salary: $163.40 per 4 wks. 26 pays in a yr. on a bi-weekly basis. Salaries have scheduled rate of increase. 48-hr. wk. 8-hr. broken day: 3-11, 11-7, rotation. Cumulative sick leave. Pension Plan in force. Blue Cross. 3 wks. vacation after 1 yr. service. Apply Supt. of Nurses, Muskoka Hospital, Gravenhurst, Ont.

Nursing Arts Instructor for teaching staff of 450-bed hospital. 165 students. Apply, stating qualifications, Director of Nursing, General Hospital, Saint John, N.B.

General Duty Nurses for modern, well-equipped hospital in picturesque Lakehead. 45-hr. wk. Cumulative sick leave. 1 mo. vacation after 1 yr. service. Gross salary per mo.: $185 less $20 for meals. A further $25 charged if living in residence. Annual increment. Railway fare up to $50 with 1 yr. contract. Also **Instructor** to assist senior instructor in teaching dept. Anatomy & Physiology, & Pharmacology chief subjects. Gross salary: $225. Apply Director of Nursing, General Hospital, Port Arthur, Ont.

Graduate Nurses for completely modern West Coast hospital. Salary: $190 per mo. less $40 for board, residence, laundry. $10 annual increments. Special bonus of $10 per mo. for night duty. 1 mo. vacation with full salary after 1 yr. service. 1½ days sick leave per mo. cumulative to 36 days. Transportation allowance not exceeding $60 refunded after 1st yr. Apply, stating experience, Miss E. L. Clement, Supt. of Nurses, General Hospital, Prince Rupert, B.C.

Operating Room Supervisor for General Hospital, averaging 30-35 operations daily. Also **General Staff Nurses** with Operating Room experience. Apply, stating age, qualifications & experience, c/o Box C, The Canadian Nurse, Ste. 522, 1538 Sherbrooke St. W., Montreal 25, Que.

Graduate Nurse for Charge of Operating Room for minor surgery in Tuberculosis Hospital. For further particulars apply Director of Nursing, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, Que.

Asst. Supervisor for Operating Room of 450-bed General Hospital. Apply, stating qualifications & salary expected, Director of Nursing, General Hospital, Saint John, N.B.

Asst. Supt. of Nurses by Aug. 15 for Provincial Mental Hospital, Ponoka, Alta. 1,450-bed active treatment hospital, conducting accredited School of Nursing. Apply, stating qualifications, experience & year of graduation, to Supt. of Nurses.

Educational Director for 220-bed hospital. Student enrolment approx. 75. Psychiatric & tuberculosis affiliation. Good working conditions. Annual vacation with pay, statutory holidays & sick leave. Apply, stating full qualifications, experience & salary expected, Supt. of Nurses, General Hospital, Brandon, Man.

Registered Nurses (**3**) for 30-bed hospital. Salary: $150 per mo. plus board & room in modern residence. $10 per mo. raise after 1 yr. Town of 1,300 pop. with excellent sport facilities. 8-hr. shift, 6-day wk. 1 mo. holiday with pay. Staff—7 R.N.'s, 2 nurse aides, 2 doctors. Write or wire collect J. H. Moysey, Sec.-Mgr., Union Hospital, Eston, Sask.

General Duty Nurses for 220-bed hospital with School of Nursing. Salary: $160 per mo. Annual increment. Cumulative sick leave. 1 mo. vacation after 1 yr. service. 8-hr. day, 48-hr. wk. Apply Supt of Nurses, General Hospital, Brandon, Man.

Graduate Nurses (**2**). Salary: $125 per mo. with $30 extra per mo. for night duty. Full maintenance with $5.00 increment every 4 mos. to $150. **Practical Nurses** (**2**). Salary: $65-90 depending on years of experience & increment of $5.00 every 6 mos. Positions open immediately. Standard arrangements re vacation. Statutory holidays & sick leave. Apply Supt. of Nurses, Altona Hospital, Altona, Man.

Asst. Instructor & General Duty Nurses for 125-bed General Hospital. Excellent salary. 8-hr. day. 4 wks. vacation with pay. Apply, stating qualifications, Supt., Soldiers' Memorial Hospital, Orillia, Ont.

Public Health Nurse for generalized service in urban municipality. Salary: $1,900-2,500 according to experience. Apply in writing, stating qualifications, experience, age, etc., Medical Officer of Health, Dept. of Health, City Hall, Kingston, Ont.

General Duty Staff. 50-bed hospital in growing community. Major services. 8-hr. day. Good salary. Pleasant apt. quarters. Cumulative sick leave. Apply Administrator, Oakville-Trafalgar Memorial Hospital, Oakville, Ont.

Matron for 15-bed hospital. Staff—4 nurses & 3 nurse aides. Apply, stating salary expected, Mrs. E. J. Tiller, Sec.-Treas., Memorial Union Hospital, Wolseley, Sask.

Operating Room Supervisor. Also **Instructors** (**2**). Good salaries. Sick leave. 1 mo. annual holiday. Blue Cross Hospital Plan. New hospital under construction. For full information apply Miss H. M. Bartsch, Charlotte County Hospital, St. Stephen, N.B.

Science Instructor & Clinical Supervisor. Full maintenance. Ideal living conditions. Apply Miss C. MacCullie, Director of Nursing, General Hospital, Woodstock, Ont.

General Staff Duty Nurses for 31-bed General Hospital. Rotating service. Gross salary: $185. Increments in 6 mos. & 1 yr. 8-hr. day. 44-hr. wk. 1 mo. vacation. Apply Matron, General Hospital, Ladysmith, B.C.

Dietitian for 107-bed hospital. Good working conditions & salary. Apply Supt., Kirkland & District Hospital, Kirkland Lake, Ont.

General Duty Nurse for 107-bed modern hospital. Starting salary: $165 per mo. plus meals & laundry. Additional for night duty. Increase at 6 mos. & annually thereafter for further 2 yrs. Transportation refunded after 6 mos. from point of entry into Ont. 30 days holiday with pay after 1 yr. service. Medical & hospital plans available. Apply Supt. of Nurses, Kirkland & District Hospital, Kirkland Lake, Ont.

General Duty Registered Nurses (**2**) immediately for 50-bed Municipal Hospital. Salary: $140 per mo. plus full maintenance with increase of $5.00 per mo. annually for experience to maximum of $155. Straight 8-hr. shifts. 24 days annual holiday. 1½ days sick leave per mo. cumulative. Separate nurses' residence. Apply Miss E. Daniel, Matron, Municipal Hospital, Peace River, Alta.

General Staff Nurses for active 35-bed General Hospital, 50 miles from Toronto. Apply Supt., Lord Dufferin Hospital, Orangeville, Ont.

Graduate Nurses for General Duty. Apply, stating qualifications, Supt., The Cottage Hospital, Pembroke, Ont.

Registered Nurse for General Duty for 20-bed hospital. Good salary. 48-hr. wk. & living-in accommodation. 12 days sick leave. 2 wks. vacation with pay. 7 statutory holidays. Apply Supt., General Hospital, Palmerston, Ont.

Registered Nurses for Operating Room & General Staff Duty for University of Alberta Hospital, Edmonton. (640 beds to be increased to 950 with opening of new wing in Sept.) Gross salary: $195 per mo.—1st yr.; $205—2nd yr.; $215—3rd yr. of service in hospital. $25 per mo. deducted for meals & laundry. 11 statutory holidays annually. Sick leave, 3 wks. after 1 yr. service with annual increase of 1 wk. to maximum of 13 wks. Blue Cross coverage on 50% employee contributory basis. Pension Plan. 1st class railway fare to Edmonton refunded after 1 yr. continuous service. Pleasant university environment. Apply Supt. of Nursing Services.

Matron. Salary: $195 per mo. less $20 for maintenance. **General Duty Nurses** (**2**). Salary: $165 per mo. less $20 for maintenance. 17-bed hospital. Pleasant working conditions. Convenient to Calgary & Edmonton. Hospital Board will pay railway fare if period of employment is 6 mos. or over. 1 mo. leave with pay after 1 yr. service. Statutory holidays. 48-hr. wk. with no split shifts. Apply A. J. Schmiedl, Sec.-Treas., Municipal Hospital, Elnora, Alta.